Grand River Specialty Clinic

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Last Name: ______________________ First Name: ______________ MI: ____

Sex: ___ Date of Birth: ____________ Age: ___ Marital Status: ____________

Present Complaint:

	Living	Dead	AgeDeath	Cause of Death
Father				
Mother				
Bro or Sis				

Family History: Has Any Blood Relative Ever Had:

	No	Yes	Who
Cancer, Including Leukemia			
Tuberculosis			
Diabetes			
Heart Trouble			
Heart Attack			
High Blood Pressure			
Bleeding Disorder			

Present Illness:

Personal History

Have you lost weight in the past year: ☐ No ☐ Yes

Allergies: Are You Allergic to Any of the Following?

	No	Yes
Pennicillin		
Sulfa		
Other Antibiotics		
Any Other Drug or Medicine		

Name:

Do You Smoke? ☐ No ☐ Yes
If Yes, How Much:

Do you Drink?
Beer: ☐ No ☐ Yes
Wine: ☐ No ☐ Yes
Other:

Please Do Not Print Below

Physical Exam	Normal	Abnormal	Details Of Abnormal Findings
Lymphatic System			
Eyes			
Ears			
Hearing			
Nose			
Mouth-Throat			
Neck			
Heart			
Lungs			
Breasts			
Abdomen			
Rectal			
Hernia			
Genitalia			
Extremities			
Spine			

Nervous System			

Medicines

Are You Taking Any Medicines Regularly Now?

☐ No ☐ Yes (Please List)

Have You Ever Taken:	No	Yes	When
Insulin			
Cortisone			
Thyroid Medicine			
Blood Pressure Medicine			
Birth Control Pills			

Other:

Operations: Have You Had Any of These Operated Upon?

	No	Yes	When
Tonsils			
Appendix			
Gall Bladder			
Thyroid			
Hernia (Rupture)			
WOMEN			
Breast			
Uterus			
Ovaries			

Other:

Diagnosed Difficulties

Do You Now, or Have You in the Past, Had Any of the Following?

	No	Yes
Heart Attack		
High Blood Pressure		
Gall Stones		
Stomach or Duodenal Ulcer		
Rectal Trouble		
Hemorrhoids or Piles		
Kidney Stones		
Anemia		
Diabetes		
Broken Bones		
Varicose Veins		
Phlebitis		
Breast Cancer		

Other Breast Disease:

Number of Times Pregnant:

Number of Children:

Number of Miscarriages:

Last PAP Smear:

Doctor:

Patient Signature: **Date:**

Remarks