Swarthmore Pediatrics & Family Medicine
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Adult

PATIENT INFORMATION

Last Name | First | Middle | Daytime Phone | Evening Phone

Address | City | State | Zip | Marital Status | Social Security #

Occupation | Employer | Employer's Address

Person to Notify in Emergency | Who may we thank for referring you: | May we contact prior Drs. for health records?

Telephone | (Please fill out form at desk)

PLEASE SIGN THE FOLLOWING IF APPLICABLE:

Medicaid Medicare PATIENTS
I request that payments of authorize Medicare/Medicaid benefits be made either to me or on my behalf to Swarthmore Pediatrics & FM for any services furnished to me by that physician or supplier. I authorize any holder of medical information about to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services.

Patient's Signature X ______________________

COMMERCIAL INSURANCE PATIENTS
I authorize the release of any medical information necessary to my insurance company to process all claims and I authorize payment of medical benefits to Swarthmore Pediatrics & FM for services rendered.

Patient's Signature X ______________________

MEDICAL HISTORY

Today's Date | Birthdate | Sex MALE FEMALE (Circle one) | Is this visit the result of an AUTO ACCIDENT ON THE JOB INJURY (If yes, circle one and advise the front desk) | Date of injury

Date of last physical exam | By Doctor | Present medical symptoms

DRUG ALLERGIES/OTHER ALLERGIES | Current Medications

Family History	IF LIVING Age	Health: Good	Fair	Poor	IF DECEASED Death Age	Death Cause
Father						
Mother						
Brothers /Sisters						
1. M F *circle sex*						
2. M F						
3. M F						
4. M F						
5. M F						
Husband/Wife						
Sons/Daughters						
1. M F *circle sex*						
2. M F						
3. M F						
4. M F						
5. M F						
6. M F						

Do YOU or ANY BLOOD RELATIVES have or have had any of the listed conditions

Condition	Yes	No	Relationship or Self	Condition	Yes	No	Relationship or Self
Asthma				Hepatitis			
Arthritis				Hay Fever			
Allergies				H I V (AIDS)			
Anemia				Kidney Disease			
Alcoholism				Leukemia			
Bleeding Tend.				Migraine			
Cancer				Nervous Disorder			
Cancer				Obesity			
Colitis				Rheumatism			
Congenital Heart				Rheumatic Fever			
Diabetes				Stroke			
Epilepsy				Suicide			
Goiter				Stomach Ulcers			
High Bl. Press.				Tuberculosis			
Heart Disease							
High Cholesterol							

HABITS

Do you (*circle one*) — *Daily Intake:*

	circle one	Daily Intake
Smoke	Y N	________ pkgs.
Drink Coffee	Y N	________ cups
Drink Alcohol	Y N	________ oz.
Drink Beer / Wine	Y N	________ oz.
Fall Asleep Easily	Y N	
Awaken Early	Y N	
Awaken At Night	Y N	

MEDICATIONS TAKEN IN PAST

Medication	circle one	Medication	circle one	Medication	circle one	Medication	circle one
Antacids	Y N	Blood Thinning Pills	Y N	Iron	Y N	Water Pills	Y N
Antibiotics	Y N	Cortisone	Y N	Laxatives	Y N	Weight Red. Pills	Y N
Aspirin, Buffern, etc.	Y N	Digitalis	Y N	Phenobarbital	Y N	Other (list) ______	
Barbiturates	Y N	Dilantin	Y N	Sleeping Pills	Y N	______	
Birth Control Pills	Y N	Hormones	Y N	Thyroid Medicine	Y N	______	
Blood Pressure Pills	Y N	Insulin, Diabetic Pills	Y N	Tranquilizers	Y N	______	

OVER

MEDICAL HISTORY (Continued)

Please Describe:
Operations you have had — Year

Serious illness not requiring hospitalization — Year

Diseases you have had requiring hospitalization — Year

Describe any serious injuries or accidents you have had

WOMEN only: (circle one)

Question	circle one	
Are you still having regular monthly menstrual periods?	Y N	
Have you ever had bleeding between your periods?	Y N	When?
Do you have very heavy bleeding with your periods	Y N	When?
Do you feel bloated and irritable before your period?	Y N	
Are you now on, or have you ever taken the birth control pill?	Y N	When?
Have you ever had a miscarriage?	Y N	When?
Have you ever had a discharge from the nipple of your breast?	Y N	When?
Do you regularly have the cancer test of the cervix?	Y N	Date of last test?
How many children born alive?	Y N	
How many stillbirths?	Y N	
How many premature births?	Y N	
Date of last menstrual period?	Y N	
How many miscarriages?	Y N	
How many cesarean operations?	Y N	
Any complications of pregnancy? (explain)	Y N	
Loss of sexual activity? (explain)	Y N	

MEN only: Have you ever had

Question	circle one	
Loss of sexual activity?	Y N	For how long?
Treatment for genitals (private parts)?	Y N	
Discharge from penis?	Y N	
Hernia (rupture)?	Y N	
Prostrate trouble?	Y N	

MEN and WOMEN:

Question	circle one
Do you frequently have severe headaches?	Y N
(If yes, answer the following):	
Do they cause visual trouble?	Y N
Do they occur on one side of the head?	Y N
Do they awaken you at night from sleep?	Y N
Do they feel like a tight hat band?	Y N
Do they hurt most in the back of the head and neck?	Y N

Have you recently had pain in the stomach which:

Question	circle one
Occurs 1-2 hours after a meal	Y N
Is brought on by eating fried foods or gassy foods?	Y N
Awakens you at night?	Y N
Is relieved with milk or eating?	Y N
Occurs while eating or immediately after?	Y N
Is relieved by a bowel movement?	Y N
Causes loss of appetite?	Y N

Question	circle one
Have you ever fainted?	Y N
Spells of dizziness?	Y N
Spells of weakness of arm or leg?	Y N
Ringing in ears?	Y N
Have you ever had a convulsion?	Y N
Double vision?	Y N
Pains in ear?	Y N
Nosebleeds?	Y N

Do You frequently have:

Question	circle one
Bleeding gums?	Y N
Trouble swallowing?	Y N
Hoarseness?	Y N
A sore tongue?	Y N
Nausea and vomiting?	Y N

Question	circle one
Have you ever had shortness of breath?	Y N
Doing your usual work?	Y N
Climbing a flight of stairs?	Y N
Which awakens you at night?	Y N
Do you have a chronic cough?	Y N
Accompanied by wheezing?	Y N
Have you ever coughed blood?	Y N
Do you cough up much sputum?	Y N

Have you had pain or tightness in the chest which begins:

Question	circle one
When exerting yourself?	Y N
When walking against the wind?	Y N
When walking up a hill?	Y N
After a heavy meal?	Y N
When upset or excited?	Y N
With palpitations?	Y N
Do you sleep on more than one pillow?	Y N
Radiates down the arm?	Y N
Disappears if you rest?	Y N
Occurs only at rest?	Y N
When walking fast?	Y N
When walking in cold weather?	Y N

If you have chest pain or tightness please explain

Have you had:

Question	circle one	When or since when?
Burning when urinating?	Y N	
Loss of control of the bladder?	Y N	
Blood in the urine?	Y N	
Dark colored urine?	Y N	
Trouble starting to urinate?	Y N	
Trouble holding the urine?	Y N	
To get up frequently at night?	Y N	
Passed a kidney stone?	Y N	

Have you recently had:

Question	circle one	When or since when?
Pains in the calves or legs when walking?	Y N	
Cramps in the legs at night?	Y N	
Pain in the big toe?	Y N	
Varicose veins?	Y N	
Phlebitis or inflamed leg veins?	Y N	
Swelling in the ankles?	Y N	

If you have had a change in bowel habit recently answer the following:

Question	circle one	When or since when?
Crampy pain in the abdomen?	Y N	
Alternating diarrhea and constipation?	Y N	
Pain during or after a bowel movement?	Y N	
Mucous in the stool?	Y N	
Blood in the stool?	Y N	
Ribbon-like stools?	Y N	
Black stools?	Y N	
Require use of strong laxatives or enemas?	Y N	

Describe briefly your present medical symptoms and anything else we should know about your health.