Skinner Family Practice, LLC
129 N. 3rd AVE, STE C
PURCELL, OK 73080-4244
405-641-6628 FAX 527-8669

Name: _____**Date**: _____ **Date of Birth**: _____

Address: _____ **Cell Number**: _____

1. State in your own words the major medical reason(s) for coming in today: Phone Number: _____

Pharmacy Name:

Pharmacy Number: _____

2. **List all medications that you use. Please bring these with you:**
MEDICATION DOSAGE MEDICATION DOSAGE

3. LIST **Drug Allergies? _____** CIRCLE **Blood Thinners** (aspirin, Vit E, Plavix, Coumadin)

4. **Family History:** please indicate the health or cause of death of members of your family as best as you can:

	Age if Living	Age at Death	Cause of death	Any serious diseases
Mother				
Father				
Brothers				
Sisters				
Children				
Spouse				
Other				

5. Please indicate which of your relatives has any of the following diseases:
Cancer: _____ Diabetes: _____
Heart Problems: _____ High Blood Pressure: _____
Kidney Disease:_____ Mental/Emotional Problems: _____
Stroke:_____ Tuberculosis: _____
Arthritis: _____ Other: _____

6. Do you use **tobacco** products**?** **HOW MUCH?** **Cigarettes/cigars/vapor/marijuana**
Do you drink **alcohol?** **HOW MUCH?** **BEER/WINE?** **HARD LIQUOR?**
Do you drink **caffeine?** **HOW MUCH?** **soda, tea, coffee**

Please complete the back page.

7. **Comment** on special problems and give approximate **DATES:**

YES		NO
	Swollen glands, lumps, or bumps	
	Recent weight loss/gain	
	Headaches or Pain in other areas	
	Trouble with hearing	
	Anesthesia complication	
	Organ transplant	
	Diabetes	
	Gout	
	Allergies: Hay Fever? Asthma?	
	Thyroid (Goiter)	
	Anemia or Abnormal Bleeding	
	Skin Problems	
	Stroke, Blood Clots, DVT	
	Heart Problems	
	Circulation Problems	
	High Blood Pressure	
	Chest Pain	
	Lung Problems (Pneumonia, TB, COPD)	
	Shortness of breath, coughing, pleurisy, wheezing	
	Liver Disease, Gallbladder disease, Jaundice	
	Stomach problems: Pain, ulcers, indigestion, change in bowels, constipation, diarrhea	
	Kidney disease or stones	
	Urination Problems	
	Joint Pain or Stiffness	
	Fainting or convulsion	
	Depression, anxiety	
	Nerves, difficulty sleeping	
	Female organs	
	Other Illness or problems	

8. Please give details of any of the following and Approximate **Dates:**

Operations:
Serious Injuries or conditions:

Menstrual History
Number of pregnancies
Number of live births
Last menstrual period
Age at menopause

PATIENT SIGNATURE_____ **DATE**_____