



**ST. JAMES FAMILY MEDICINE – DR. AMY FORREN**

**Patient’s Full Name:** \_\_\_\_\_ **Date of birth:** \_\_\_\_\_

**Guardian:** \_\_\_\_\_ **Referred by:** \_\_\_\_\_

**Reason for today’s visit:** \_\_\_\_\_

**Please provide the following information to help us better care for you:**

**Allergies and Types of Reactions:** \_\_\_\_\_

**Known medical problems:** \_\_\_\_\_

**Current Medicines and Dosages:** \_\_\_\_\_

**Other physicians caring for you:** \_\_\_\_\_

**Family history of medical problems:** \_\_\_\_\_

**Last tetanus shot** \_\_\_\_\_ **Last menstrual period** \_\_\_\_\_ **Are you pregnant:** \_\_\_\_\_

**Occupation:** \_\_\_\_\_ **Marital Status:** \_\_\_\_\_

**Do you smoke?** \_\_\_\_\_ **If yes, how much and for how long?** \_\_\_\_\_

**Do you drink alcohol?** \_\_\_\_\_ **If yes, what type and how much?** \_\_\_\_\_

**Please circle if you have been treated for or currently have any of the following:**

- |                             |                           |                          |                             |
|-----------------------------|---------------------------|--------------------------|-----------------------------|
| <b>Cancer</b>               | <b>Anemia</b>             | <b>Prostate Problems</b> | <b>Bleeding Disorders</b>   |
| <b>High Blood Pressure</b>  | <b>Thyroid Disease</b>    | <b>Female Problems</b>   | <b>Stomach Disorders</b>    |
| <b>Heart Disease</b>        | <b>Hearing Problems</b>   | <b>Anxiety</b>           | <b>Intestinal Disorders</b> |
| <b>Heart Valve Problems</b> | <b>Speech Problems</b>    | <b>Depression</b>        | <b>Difficulty Eating</b>    |
| <b>Poor Circulation</b>     | <b>Eye Disease</b>        | <b>Seizures</b>          | <b>Cholesterol Problems</b> |
| <b>Blood Clots</b>          | <b>Infectious Disease</b> | <b>Sleep Disturbance</b> | <b>Liver Disease</b>        |
| <b>Stoke</b>                | <b>Immune Disorders</b>   | <b>Asthma</b>            | <b>Substance Abuse</b>      |
| <b>Diabetes</b>             | <b>Arthritis</b>          | <b>Emphysema</b>         | <b>Muscle Weakness</b>      |
| <b>Leg/Foot Ulcers</b>      | <b>Kidney Disease</b>     | <b>Tuberculosis</b>      | <b>Nerve Disorders</b>      |
| <b>Extreme Weight Loss</b>  | <b>Bladder Problems</b>   | <b>Coughing Blood</b>    | <b>Chronic Pain</b>         |

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_