NAPERVILLE FAMILY CLINIC

1831 Bay Scott Cir.
Naperville, IL 60540
Ph. 630-961-1341

Name _____ Today's Date _____

DOB _____ Age_____ SSN #_____ Email:_____

Marital Status _____ Occupation_____

Male Female Other _____ Sexual Orientation_____ Ethnicity_____

Preferred Language_____ **Do you feel safe at home?** _____

Reason for today's visit_____

HEALTH MAINTENANCE *List the most recent date for each of the following*

WOMEN ONLY	BOTH MEN AND WOMEN	MEN ONLY
LMP _____	Cholesterol Testing_____ Pneumonia Vaccine_____	Digital Rectal Exam_____
Mammogram_____	Colonoscopy _____ Tetanus booster _____	PSA (prostate specific antigen_____
Pap Smear _____	Bone Density (DEXA)_____	

CONDITIONS *Check conditions that you currently have or have had in the past*

AIDS/HIV	Breast lump	Emphysema/COPD	Hepatitis	Rheumatic fever
Alcoholism	Bronchitis	Epilepsy	Herpes	STD/STI
Anemia	Bulimia	GERD	High blood pressure	Stroke
Anorexia	CAD/Heart disease	Glaucoma	Kidney disease	Suicidal attempt
Anxiety	Cancer, type_____	Goiter	Liver disease	Thyroid problem
Arthritis	Chemical dependency	Gout	Multiple sclerosis	TB
Asthma	Depression	Headaches	Pacemaker	Ulcers
Bleeding disorder	Diabetes, type	Heart attack	Prostate problem	Vaginal Infection

ALLERGIES?

No known allergies **Yes, I have the following allergies**

MEDICATIONS: *List all the medications you are currently taking including the doses and frequency*

SOCIAL HABITS

Coffee	None	_____ drinks per day
Tobacco	None	_____ cigarettes per day Former _____ Vaping _____ Chew_____
Alcohol	None	_____ drinks per
Drugs	None	
Diet	Describe	
Exercise	Describe	
Seat Belt	Always Never	Sometimes

SURGICAL HISTORY

PREGNANCY HISTORY

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Year	Type of surgery/Complications, if any	Hospital	# Pregnancies ____# living children ___ # Deliveries ___ C-section____Vaginal ___		
			Yr of Birth	M or F	Complications, if any

OTHER HOSPITALIZATIONS, SERIOUS ILLNESS , INJURIES

Year	Hospital	Reason for hospitalization
Have you ever had a blood transfusion	No	Yes

Relation	Age, if living	Age at death	Medical conditions/cause of death	Disease	Relation
Father				Arthritis	
Mother				Asthma	
Brothers				cancer	
				Diabetes	
				Gout	
				Heart disease	
Sisters				HTN	
				Kidney disease	
				Stroke	

I certify that the information on this form is correct to the best of my knowledge. I will hold my doctor or any members of his/her staff responsible/e for any errors omissions that I may have made in the completion of this form.

Patient Signature ---------- **Date:** ----------