## Tracey H. Stokes M.D.

# Personal History Intake Form

This information is confidential

Date_____

Last Name _____ First_____ Middle_____ Date of Birth_____ Age___

HT._____ WT._____ Sex M F Marital Status ○ Married ○ Single ○ Divorced ○Widowed

Date of last physical exam_____ Doctor_____ Referring Doctor_____ Phone _____

Purpose of consultation _____

**Past Medical History- Do you have or have you been treated for any of the following:**

| | | | |
|---|---|---|---|
| THYROID DISEASE | N Y | BREAST CANCER | N Y |
| HEART DISEASE | N Y | OTHER CANCER | N Y |
| KIDNEY DISEASE | N Y | DIABETES | N Y |
| GALLBLADDER DISEASE | N Y | ASTHMA | N Y |
| LIVER DISEASE | N Y | LUPUS | N Y |
| HEPATITIS | N Y | FIBROMYALGIA | N Y |
| BLEEDING DISORDERS | N Y | ARTHRITIS | N Y |
| HYPERTENSION | N Y | RHEUMATOID ARTHRITIS | N Y |
| SEIZURES | N Y | SCLERODERMA | N Y |
| AIDS OR HIV | N Y | LUNG DISEASE | N Y |
| GASTROINTESTINAL DISEASE | N Y | OTHER | N Y |

PLEASE LIST:_____ _____ _____ _____ _____

**Family History- Have blood relative had any of the following, if yes, please list relationship:**

| | | | |
|---|---|---|---|
| BLEEDING DISORDERS | N Y_____ | ASTHMA | N Y_____ |
| DIABETES | N Y_____ | BREAST CANCER | N Y_____ |
| HIGH BLOOD PRESSURE | N Y_____ | OTHER CANCER | N Y_____ |
| ARTHRITIS | N Y_____ | STROKE | N Y_____ |
| OTHER | N Y_____ | | |

PLEASE LIST: _____

**Medication- Are you presently taking any of the following medication?**

| | | | | | |
|---|---|---|---|---|---|
| ASPIRIN/ANACIN | N Y | COUGH MEDICINE | N Y | WATER PILLS | N Y |
| BUFFERIN | N Y | BIRTH CONTROL | N Y | PHENOBARBITAL | N Y |
| MOTRIN | N Y | INSULIN/DIABETIC PILL | N Y | CORTISONE | N Y |
| IBUPROFEN | N Y | BLOOD THINNERS | N Y | PREDNISONE | N Y |
| ARTHRITIS | N Y | DIGITALIS | N Y | THYROID PILLS | N Y |
| ANTIBIOTICS | N Y | IRON | N Y | BLOOD PRESSURE | N Y |
| DILANTIN | N Y | SLEEPING PILLS | N Y | OTHER_____ | N Y |
| HORMONES | N Y | DIET AIDES | N Y | | |

| | | |
|---|---|---|
| **ALLERGIES** | **N Y** | **Please list all substances/medications you are allergic to:** _____ |
| Do you take herbal supplements? | N Y | Please list _____ _____ _____ _____ |
| Do you regularly smoke? | N Y | How much per day _____ For how long have you smoked_____ |
| Do you regularly drink alcohol | N Y | How much per week_____ |

**Please list and give dates of any surgeries, illnesses or injuries**

Illness/injury _____ date: _____ Surgery_____ date: _____

Illness/injury _____ date: _____ Surgery_____ date: _____

Surgery_____ date: _____

**Women Only:**

| | | |
|---|---|---|
| Is there a chance that you might be pregnant? | N Y | |
| Have you ever been pregnant? | N Y | If yes, how many?___ How many children? ____ |
| Any complications with pregnancies? | N Y | Specify: _____ |
| Did you breast feed? | N Y | |
| Have you had a mammogram? | N Y | Date: _____ Report _____ |
| Breast Cancer treatments? | N Y | Date and type of treatment: _____ ○ right breast ○ left breast |
| Breast biopsy or mastectomy | N Y | Dates: _____ _____ _____ ○ right breast ○ left breast |

Oncologist: _____ Surgeon: _____