

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

Do you take herbal supplements? N Y
Do you regularly smoke? N Y
Do you regularly drink alcohol N Y

Please list all substances/medications you are allergic to: _____

Please list _____
How much per day _____ For how long have you smoked _____
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: _____