

Name: _____

H – Phone: _____

Address: _____

W – Phone: _____

Street

City State Zip

Cell Phone: _____

DOB: _____ Age: _____ Sex: _____ Social Security Number: _____

Employed: Yes _____ No _____ Retired _____ Place of Employment: _____

Occupation: _____ Primary Physician: _____

Emergency Contact: _____ **Phone:** _____

Relationship: _____

Spouse Name: _____ Age: _____

Number of Children: Male _____ Age _____ Female _____ Age _____

Male _____ Age _____ Female _____ Age _____

Smoker: Yes _____ No _____ Number of Years _____ Packs per Day _____

Alcohol Consumption: _____ Coffee: _____ Sleep Pattern: _____

Previous Hospitalization(s): _____

Previous Surgery(s): _____

Past Medical History:

Arthritis	Kidney Disease	Anemia
Diabetes	Radiation Therapy	Chemotherapy
Phlebitis	Rheumatic Fever	Jaundice
Heart Attack	Tuberculosis	Sinus Problems
Stroke	Bleeding Tendency	Pneumonia
Transfusions	Bronchitis	Asthma
Thyroid Disease/Goiter	Hypertension	Emphysema
COPD	Congestive Heart Disease	Nervous Breakdown

ALLERGY NON-DRUG: _____ **REACTION:** _____

ALLERGY DRUG: _____ **REACTION:** _____

ALLERGY FOOD/SEAFOOD: _____ **REACTION:** _____



EAU CLAIRE MEDICAL CLINIC^{SC}

Immunization: Tetanus _____ Flu Vaccine _____ Pneumonia _____

Current Medications: _____

Other Medical Problems: _____

Family History:

Family Member	Age	Living	Major Illness
Father			
Mother			
Brothers			
Sisters			

Immediate Family with any of the following:

Cancer	Alcoholism
Goiters	Allergy
Kidney Disease	Bleeding Tendency
Tuberculosis	Asthma

Additional Comments:

How did you learn of our Clinic? _____

Signature: _____ Date: _____