Today's Date _____

KERNODLE CLINIC FAMILY PRACTICE – ELON
908 S. Williamson Ave.
Elon, NC 27244

Patient Name: _____ Date of Birth: ____/____/____ Age: _____

Social Security Number: _____-_____-_____ E-mail address _____

Address: _____ Telephone:

_____ Home: ( ) _____-_____

_____ Work: ( ) _____-_____

Employer: _____

Name and address of person responsible for payment of account: _____

_____

_____

Relative (in case of emergency): _____ Relationship: _____

Relative's Address: _____ Telephone:

_____ ( ) _____-_____

Do you have a living will? Y N Are you an organ donor? Y N

PAST MEDICAL HISTORY

Circle any of the following medical conditions you have ever had:

Allergies or Asthma	Depression	Hemorrhoids	Osteoporosis
Alcoholism	Diabetes	Hepatitis (Jaundice)	Phlebitis
Anemia	Drug Abuse	Hernia	Pleurisy
Arthritis	Eczema – Hives	High Blood Pressure	Psoriasis
Breast Lumps/Cysts	Epilepsy or Seizures	Kidney Stones	Stroke
Cancer (Tumor)	Glaucoma	Liver Disease	Suicide Attempt
Cataracts	Gout	Lung Disease	Thyroid Disease
Chicken Pox/Shingles	Heart Attack	Menstrual Problems	Ulcer
Congestive Heart	Heart Blockage	Migraines	Venereal Disease

Other: _____

List any Hospitalizations or Surgeries and the year they occurred:

_____ _____

_____ _____

Medications: [List all you take and its dose (strength and how often you take it)]

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

REACTION TO MEDICATION: (List medication name and reaction to medication)

IMMUNIZATIONS: Tetanus (within 7 years) Y / N Pneumovax (Date): _____

SOCIAL HISTORY:

Are you (circle one): Married Single Divorced Widowed
Children? Y N Ages? _____
Occupation: _____ (list last if retired)
Use Tobacco? Type _____ How much per day? _____ (packs/cans)
Use Alcohol? Type _____ Amount per day? _____ Weekends? _____
Do you use any other drugs/marijuana? Yes / No Type: _____
Do you exercise? Y N Number of times per week? _____ Minutes each time? _____
How many times per week do you eat: red meat _____; fast foods _____; fried foods _____

FEMALE PATIENTS ONLY:

How many total times pregnant? _____ How many babies? _____ Miscarriages/Abortions? _____
Date of last menstrual period: _____ Are your periods regular? Y N
When was your last PAP smear? _____ Has it ever been abnormal? Y N
When was your last mammogram? _____ Has it ever been abnormal? Y N
Have you ever experienced urinary incontinence (leaking of urine)? Y N

{Please see the following pages..}