GOOD SAMARITAN CARE MEDICAL CLINIC **DATE:________________**

DO YOU HAVE INSURANCE, MEDICAID, MEDICARE, or VETERAN'S BENEFITS? **Yes No**

PATIENT HISTORY FORM **Sex: M or F** **Referred By:____________________________**

Last Name: ______________________First Name:________________Middle Initial:_____

Date of Birth:_____________SS#:_______________Married: Yes No (If yes, add name.)

Spouse's Name:____

Mailing Address:____County:______________

City, State, Zip:____

Home Phone:___________________________Work or Cell Phone:___________________

CURRENT MEDICATIONS	**DRUG ALLERGIES**
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

HABITS (*circle Y for yes, N for no)*

Smoking	Y/N	# packs daily _______	Have you stopped?	Y/N	When?_______
Drinking	Y/N	# drinks daily _______	Have you stopped?	Y/N	When?_______

MEDICAL HISTORY

		FAMILY HISTORY			FAMILY HISTORY			FAMILY HISTORY
Allergies/Hay Fever	Y/N	□	Epilepsy	Y/N	□	Mental Illness	Y/N	□
Anemia	Y/N	□	Gallbladder Disease	Y/N	□	Mumps	Y/N	□
Anxiety	Y/N	□	GI Disorder	Y/N	□	Pneumonia	Y/N	□
Arthritis	Y/N	□	Glaucoma	Y/N	□	Mumps	Y/N	□
Asthma	Y/N	□	Gout	Y/N	□	Rheumatic Fever	Y/N	□
Bronchitis	Y/N	□	Heart Disease	Y/N	□	Scarlet Fever	Y/N	□
Cancer	Y/N	□	Heart Murmur	Y/N	□	Seizures	Y/N	□
Chest Pain	Y/N	□	Hepatitis	Y/N	□	STD's / HIV	Y/N	□
Depression	Y/N	□	High Blood Pressure	Y/N	□	Stroke	Y/N	□
Diabetes	Y/N	□	Kidney Disease	Y/N	□	Thyroid Disease	Y/N	□
Dizziness/Fainting	Y/N	□	Measles/Rubella	Y/N	□	Vascular Disease	Y/N	□

HOSPITALIZATIONS OR SURGERIES

Reasons/Dates:____

- -O-P-T-I-O-N-A-L- -

Do you have a need you would like to discuss with a minister? **YES________**
<u>If so</u>, please sign below & indicate your religious preference.
(ex: no preference, Assembly of God, Baptist, Catholic, Methodist, Nazarene, Presbyterian, etc.)

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