Port Gamble S'Klallam Medical Clinic

Date: _____Name: _____ Date of Birth:_____

1. Medical History (check problems you have had)

__Anemia	__Alcoholism	__Headaches
__Pneumonia	__Asthma	__Drug Addiction
__Venereal Disease	__Ear Problems	__Heart Disease
__Bowel Problems	__Malaria	__Hepatitis
__Bleeding Problems	__Rheumatic Fever	__Mononucleosis
__Diabetes	__Kidney Problems	__Ulcers
__Seizures	__Thyroid Disorders	__High Blood Pressure
__Cancer	__Mental Disorder	__Lung Problems
__Shoulder, Neck, Back or leg problems	__Loss of Consciousness	__Tuberculosis
	__Depression	__Bladder Infection

Other: _____

2. Are you allergic to any medications? Yes___ NO___. If yes please list: _____
_____

3. List any medications you are currently taking: _____
_____

4. Name of previous physician / clinic: _____

Any previous hospitalizations or surgeries? Yes___ No ___. If yes please list: _____
_____

5. Family History: (Check if any relatives have had any of the following conditions and indicate their relationship to you and their age when ill)

__Diabetes_____	__Alcoholism_____
__Cancer_____	__Kidney Problems_____
__Heart Trouble_____	__Ulcers_____
__Tuberculosis_____	__Mental Illness_____
__High Blood Pressure_____	__Blackouts_____
__Arthritis_____	__Allergies_____
__Obesity_____	__Thyroid Trouble_____

__Other_____

6. Health Habits: Do you Smoke? Yes___ No___, Do you use alcohol? YES___ No___,
Do you use drugs? Yes___ No___

Remarks:
_____
_____