M.D. CLAIBORNE & ASSOCIATES, L.L.C.

MEDICAL/SOCIAL/FAMILY HISTORY FORM

Name:_____Today's Date:____/____/____

Medical History:

Drug Allergies: ☐ Yes ☐ No (If yes, please list)_____
Pharmacy: Walgreens Rite Aid CVS Walmart Winn Dixie Majoria other:_____
Pharmacy telephone number: (____) _____
Are you currently taking any blood thinners? ☐ Yes ☐ No (If yes, please list)_____
Name of primary doctor:_____ telephone number:(____)_____

Current and Past Medical Conditions and/or Diseases: (Please check all that apply)

	YES	NO		YES	NO		YES	NO
Diabetes:	☐	☐	Chronic Bronchitis:	☐	☐	Heart Murmur:	☐	☐
Asthma:	☐	☐	COPD:	☐	☐	Irregular Heartbeat:	☐	☐
Thyroid:	☐	☐	Shortness of Breath:	☐	☐	Pacemaker:	☐	☐
Kidney:	☐	☐	High Blood Pressure:	☐	☐	Phlebitis:	☐	☐
Bladder:	☐	☐	Heart Attack:	☐	☐	Ulcers:	☐	☐
GERD:	☐	☐	Blood Clots:	☐	☐	Bladder:	☐	☐
Seizures:	☐	☐	Arthritis:	☐	☐	Hepatitis:	☐	☐
Cancer:	☐	☐	Skin Cancer:	☐	☐	Melanoma:	☐	☐
Keloids:	☐	☐	HIV:	☐	☐	AIDS:	☐	☐

Other:_____ _____

Please list all treating physicians for any conditions checked above:
_____ telephone: _____
_____ telephone: _____

Surgical History:

Reaction to anesthesia including dental? ☐ Yes ☐ No
(If yes, please list symptoms)_____

Past surgeries: ☐ None ☐ Yes (please list below)
_____Date:_____ Physician name: _____
_____Date:_____ Physician name: _____
_____Date:_____ Physician name: _____
_____Date:_____ Physician name: _____

****please turn form over to complete****

Family History:

Are mother and father currently living? ☐ Yes ☐ No
If not, cause of death: _____
How many siblings to you have? _____
Are all siblings still living? ☐ Yes ☐ No
If not, cause of death: _____

Social History:

Occupation: _____ Years: _____
Amount of daily sun exposure: _____hrs _____mins
Do you drink alcohol? ☐ Yes ☐ No
If yes, number of drinks per day: _____
Do you smoke?
If yes, how many cigarettes a day? (Circle One please) Pack Half Pack Less
Do you use an electronic cigarette? ☐ Yes ☐ No
Do you use illegal drugs? ☐ Yes ☐ No
Do you use tanning booths? ☐ Yes ☐ No Yes, what is the last date used: _____/_____/_____
Any international travel within last 6 months? ☐ Yes ☐ No
Any exposure to chemicals? ☐ Yes ☐ No
If female, are you currently pregnant? ☐ Yes ☐ No
Are you a vegetarian? ☐ Yes ☐ No
Do you currently wear sunscreen? ☐ Yes ☐ No
What are your hobbies?

_____

By signing this form you attest that all information provided is true and accurate at date listed on this form. Furthermore, by signing this form, you hereby release M.D. Claiborne & Associates, L.L.C. from all responsibilities and liabilities whether financial, medical or loss of life associated with treatment and care provided by its physicians and staff based on the information you have listed. We reserve the right to refuse treatment based on any finding of false or inaccurate information contained on this form.

_____ _____
Signature of Patient Date

_____ _____
Signature of Staff Date