# 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 number: (______) _____________

______________________________telephone number: (______) _____________

## 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:_________________

## Family History:

Are mother and father currently living? __Yes __No
If not, cause of death:_____________________________________________________
How many siblings do you have?_________
Are all siblings still alive? __Yes __No
If not, cause of death:_____________________________________________________

## Social History:

Occupation:________________________________________________Years:________
Amount of daily sun exposure:_________hours_________Minutes
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 If 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