WHITFORD
FAMILY MEDICINE

Name: ______________________________ Date: ______________

In an attempt to help us transition your medical history into an electronic medical record, please take a moment to complete the following questionnaire so that we may have the most accurate information available. Please answer as best you can and we will help retrieve any information you cannot recall.

Birthdate: ______________________________

Address: ______________________________

Telephone: ______________________ Mobile: ______________________

Occupation: ______________________________

The following individual(s) may receive medical information from our office regarding my care:

____

____

Consent to leave message with results/medical information? ☐ Yes ☐ No

How would you prefer to receive Medical Information (ie, Test Results, etc.)

☐ Telephone Call — Best Number to reach you: ______________________

☐ Electronic Message (Email) — Email Address: ______________________

Do you have a Living Will? ☐ Yes ☐ No

What are the names of the Specialists that you see?

Name	Specialty

Which Hospital do you prefer to use in our area?

☐ Paoli Memorial Hospital
☐ Brandywine Hospital
☐ Chester County Hospital
☐ Phoenixville Hospital

Medical History (Please explain if necessary):

___ High Blood Pressure
___ High Cholesterol
___ Diabetes
___ Cancer
___ Heart Disease
___ Stroke
___ Orthopedic Problems
___ Gynecologic Problems
___ Digestive Problems
___ Urologic Problems
___ Asthma
___ Environmental Allergies
___ COPD/Emphysema
___ Other Respiratory
___ Headaches (migraine)
___ Arthritis
___ Anemia
___ HIV
___ Sexually Transmitted Diseases
___ Hepatitis (A, B, or C)
___ Rheumatoid Disorders
___ Thyroid Problems
___ Skin Problems
___ Glaucoma
___ Sinus Problems
___ Prostate Problems
___ Alcoholism
___ Drug Addiction
Other:

Further explanations for any of the above: ______________________________

____

____

Surgical History (with approx. dates): ______________________________

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________
6. ______________________

Do you exercise regularly? ☐ Yes ☐ No

If yes, what type of exercise do you participate in and how often? ______________________

If Applicable, when was your last:

Study/Exam	Year
Colonoscopy	______________________
Mammogram	______________________
Pap Test	______________________
Prostate Examination	______________________
EKG	______________________
Bone Density Study	______________________

Have you had the following and if so, when?

Pneumonia Vaccine	______________________
Tetanus Booster	______________________
Shingles Vaccine	______________________
HPV Vaccination	______________________

Medications (Including OTC's) Name and doseage.

ALREADY ON FILE IN CHART? ☐ YES, NOTHING NEW

PLEASE ADD THE FOLLOWING TO MY RECORD:

1.______________________	7.______________________
2.______________________	8.______________________
3.______________________	9.______________________
4.______________________	10.______________________
5.______________________	11.______________________
6.______________________	12.______________________

Medication Allergies:

1. ______________________

2. ______________________

3. ______________________

4. ______________________

5. ______________________

6. ______________________

7. ______________________

Family History:	Living/Age	Deceased/Age	Medical Problems
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Social History:

Marital Status ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Children? ☐ How many?__________

Smoking History: ☐ No ☐ Yes (How much? How many years?) Quit (When? How many years?)

Cigarettes______________________

Cigars______________________

Chewing Tobacco______________________

Marijuana ______________________

Alcohol: How much? How often? ☐ NEVER

Beer ______________________

Wine______________________

Hard Liquor ______________________

I CERTIFY THAT THE INFORMATION I HAVE PROVIDED ABOVE IS CORRECT, AND GIVE CONSENT TO HAVE THIS INFORMATION ENTERED INTO MY ELECTRONIC MEDICAL RECORD.

Patient or Guardian Signature ______________________