Carlisle Family Care

1533 Commerce Ave., Suite 1, Carlisle, PA 17015 Phone (717) 240-1322 Fax (717) 240-0382

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Name: ____ Date: ____________________________________

Age: _____________ DOB: _______________________ Occupation: _____________________________________

Height: feet ________ inches _________ Weight: ___________

Do you have an Advanced Directive or Living Will? Yes _____ No _____ *If yes, please provide a copy

EMERGENCY CONTACT:
1). Name: ____________________________________ Relationship: _______________________________
Phone (home) _____________________________ (other) ______________________________
If necessary may I discuss your medical care with this person? Yes ____ No ____

Previous Surgeries:

Type of surgery	Date

Chronic Health Conditions (such as Diabetes, Hypertension, High Cholesterol, etc.)

1. ______________________________ 2. ___________________________ 3. _________________________

4. ______________________________ 5. ___________________________ 6. _________________________

Allergies to Medication: ____
____

Current Medications and Dosages: (list all prescription and non-prescription medications, including herbal supplements)

Medication	**Dosage**	**Directions**

<u>All patients 12 years and older:</u>
If female, are you now pregnant? Yes ______ No ______ If yes, what is your due date? ___________________

Do you smoke? Yes ____ No _____ If yes, how many packs per day? ____ Chewing Tobacco? Yes____ No_____

Do you drink alcohol? Yes ____ No ____ If yes, how much and how often? ______________________________

Do you use street drugs? Yes ____ No ____ If yes, how much and how often? ____________________________

Reviewed by ____ Date ___________________
(Office Staff Only)