NORTHSIDE
SUWANEE
PRIMARY CARE
A Northside Network Provider

1120 Peachtree Industrial Blvd.
Suite 208
Suwanee, GA 30024
P 678-312-8400
F 770-904-2601

Pt Name: _____ DOB: _____

Date of Last Physical Exam: _____

Patient Concerns:

1. _____

2. _____

FAMILY MEDICAL HISTORY

	✓ IF ALIVE	Age at Death	Present Health/Cause of Death		#Alive	#Deceased	Present Health/Cause of Death
Father				Brothers			
Mother				Sisters			
Spouse				Children			
				Ages of Living Children:			

CHECK (✓) ALL THAT APPLY TO YOU HEALTH, PAST OR PRESENT.

☐ DIABETES ☐ CANCER ☐ BLEEDING TENDENCY ☐ KIDNEY DISEASE ☐ TUBERCULOSIS ☐ THYROID
☐ HEART DISEASE ☐ STROKE ☐ HIGH BLOOD PRESSURE ☐ DEPRESSION ☐ ALLERGIES ☐ ANEMIA

MEDICATIONS

CURRENT MEDICATIONS, VITAMINS, SUPPLEMENTS, ETC.

_____

_____

_____

_____

_____

FOR WOMEN:

LAST PAP SMEAR: _____

LAST MAMMOGRAM: _____

LAST MENSTRUAL PERIOD: _____

NUMBER OF PREGNANCIES: _____

DO YOU USE CONTRACEPTIVES: YES ☐ NO ☐

IF YES, PLEASE LIST ALL _____

_____

ALLERGIES

CHECK (✓) IF YOU ARE ALLERGIC TO:

☐ ADHESIVE TAPE ☐ ASPIRIN
☐ IBUPROFEN ☐ IODINE
☐ LATEX ☐ LOCAL ANESTHESIA
☐ PENICILLIN ☐ SULFA
☐ OTHER _____

_____

_____

PREFERRED PHARMACIES

LOCAL _____ Ph. _____

MAIL ORDER _____ Ph. _____

PLEASE LIST ALL THE FOLLOWING THAT APPLY TO YOU (use the back of this page if needed):

CHRONIC CONDITIONS

_____

_____

ACCIDENTS

_____

_____

DIAGNOSTIC TESTS

_____

_____

INJURIES/ILLNESSES

_____

_____

HOSPITALIZATIONS

_____

_____

SURGERIES

_____

_____

OTHER HEALTHCARE PROVIDERS

CARDIOLOGIST _____ OTHER _____

OB/GYN _____ OTHER _____

CERTIFICATION

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

_____ _____

Signature of Patient, Parent, Guardian or Personal Representative Date

Reorder #57003 PP0996 (SPC)
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MEDICAL HISTORY