CARLISLE MEDICAL CENTRE

Welcome! To help us get your medical records up-to-date, it would be very helpful if you complete this form.

Name: ____________________________________ Age:____ Occupation:____________________

<u>Medical Conditions</u> you have been diagnosed with in the past:
Examples: Diabetes, Blood Pressure, Depression, Anxiety, Cancer, Heart Attack, Stroke, Arthritis

___________________________ ___________________________ ___________________________

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<u>Previous Surgeries</u> and year performed*: Example: Tonsils 1956, Wisdom Teeth 2005*

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Did you have any allergic reaction to the anesthetic? Yes ___ No ___

<u>Family History:</u> *Examples: Cancer, Heart Attack, Aortic Aneurysm, Stroke, , Diabetes*
****Please include age of diagnosis when possible** Example Heart Attack Age 55**

Mother: ____
Father: ____
Siblings: ____
Children: ____
Other: ____

<u>Medications:</u> + Dose*(Please include non-prescription medications, herbs and supplements)*

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

Smoker or Ex-Smoker Yes __ No__ Years Smoked?___ Packs per Day ___ Year Quit___
Alcohol Drinks per Day/Week: ___ (1 drink=12 oz beer or 4 oz wine or 1.5 oz spirit)
Recreation Drugs: Marijuana ___ Cocaine ___ Other: ______

Allergies:

___________________________ ___________________________ ___________________________

___________________________ ___________________________ ___________________________

Year of last: Colon Cancer Screening (Stool Test/Colonoscopy _____ Tetanus Shot _____
PAP_____ Breast Cancer Screening_____ Bone Density _____

Please use the back to elaborate on anything that you would like to add orto discuss something that was not covered and you would like me to know. . Thank you for taking the time to complete this.