STEPHEN E. FRY M.D., P.C.
CONFIDENTIAL PATIENT INFORMATION.

NAME: ____

DATE: ____

REASON FOR VISIT:

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PRIOR MEDICAL HISTORY:
(INCLUDE OPERATIONS, HOSPITALIZATIONS, MAJOR ILLNESS AND MEDICAL TREATMENTS)

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MEDICATIONS TAKEN: (PRESCRIPTION AND NON-PRESCRIPTION)

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CURRENT OR PRIOR HISTORY OF ANY SUBSTANCE ABUSE:

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ALLERGIES: (TO MEDICATIONS OR OTHER)

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IMMUNIZATION STATUS

UP TO DATE ____________________

DO NOT KNOW ____________________

PERSONAL HISTORY

PLACE OF BIRTH: ____________________ CHILDREN: ____________________

MARITAL STATUS: ____________________ LAST PHYSICAL: ____________________

FOREIGN TRAVEL HISTORY: ____

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FEMALES

LAST MENSTRUAL PERIOD: ____________________ LAST PAP SMEAR: ____________________

LAST MAMMOGRAM: ____________________ HYSTERECTOMY: ____________________

-TURN OVER-

SMOKING HISTORY

NON-SMOKER
I QUIT________ YEARS AGO

SMOKER
OF PACKS PER DAY_______

ALCOHOL INTAKE

NUMBER OF DRINKS PER WEEK _____________________

STRESS LEVEL

HIGH MEDIUM LOW

REGULAR EXERCISE

TYPE:______________________________________ DURATION:_____________________________________

FREQUENCY:____

DIET

DESCRIBE YOUR EATING HABITS: (FOOD INTOLERANCE, SPECIAL DIETS, NUTRITIONAL HABITS, ETC)

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FAMILY HISTORY

CORONARY HEART DISEASE
LUNG CANCER
STROKE
HIGH BLOOD PRESSURE
ARTHRITIS

BREAST CANCER
DIABETES
COLON CANCER
ASTHMA
ALLERGIES

OTHER:____

LIST OTHER INFORMATION YOU FEEL MAY BE INPORTANT FOR THE DOCTOR TO KNOW:

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LIST DOCTORS YOU HAVE SEEN IN THE LAST 2 YEARS AND REASON WHY:

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REFERRAL INFORMATION

HOW DID YOU LEARN ABOUT DR. STEPHEN E. FRY M.D., P.C.?

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