John S. Bickle, D.O.

PATIENT HISTORY

Name:	Date of Birth:	Age:	Occupation:

Have you ever had or now have problems with:

	Yes	No		Yes	No		Yes	No
Anxiety / depression			Heart Trouble			Migraines		
Asthma / emphysema			Kidney Disease			Thyroid Disease		
Bleeding Tendencies			Mental Illness			Bleeding Disorder		
Blood clots			Valley Fever			Chronic Back Pain		
Cancer			Arthritis			Other		
Diabetes			Seizures					
Glaucoma			Tuberculosis					
High Blood Pressure			STD's					
High Cholesterol			Stroke					

Family History	**Age(s)**	**Medical Problems:**
Father		
Mother		
Brothers No: _____		
Sisters No: _____		

Have you ever had any operations? Y ☐ N ☐ If yes, please list:

Year	Operation	Year	Operation	Year	Operation

List other illnesses **not** requiring an operation for which you were hospitalized:

Do you have any **allergies** or sensitivities to medicines or other substances? Y ☐ N ☐ If yes, please list with type of reaction:

Do you have any religious or cultural beliefs which may affect your care with Black Mountain Family Medicine? Y ☐ N ☐ If yes, please explain:

Medications: name or otherwise identify over-the-counter, herbal, natural remedies or prescription medications, including oral contraceptives, now or recently used:

Do you have an Advance Directive (Living Will) in place? Y ☐ N ☐

Tobacco use now Y ☐ N ☐	Past Y ☐ N ☐	Type/amount:	How long:
Alcohol use now Y ☐ N ☐	Past Y ☐ N ☐	Type/amount:	How long:
Marijuana or street drug use now Y ☐ N ☐	Past Y ☐ N ☐	Type/amount:	How long:

Check the diseases against which you have been Immunized: Hepatitis B ☐ Hepatitis A ☐ Pneumovax ☐ MMR ☐
Tetanus ☐ Polio ☐ Diphtheria ☐ Influenza ☐ Other:

Date of last Pap smear:	Date of last Mammogram:
Number of pregnancies:	Number of live births:
Are you sexually active? Y ☐ N ☐	Have you ever experienced any form of abuse? Y ☐ N ☐
Have you ever had a blood transfusion? Y ☐ N ☐	Date:

Is there anything that you would like to discuss with your physician in confidence? Y ☐ N ☐

Patient Signature: Date:

Physician/Provider Signature: Date: