



Name \_\_\_\_\_

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Occupation \_\_\_\_\_  
 Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_  
 Chief complaint \_\_\_\_\_

**DRUG ALLERGIES**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY**

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**CURRENT MEDS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**HOSPITALIZATION OR SURGERY**

Reason	Date	Reason	Date
_____	_____	_____	_____
_____	_____	_____	_____

**WOMEN ONLY:** Pregnant?  Yes  No Planning pregnancy?  Yes  No

**MEDICAL HISTORY**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Headache _____                    | <input type="checkbox"/> Lactose intolerance _____          | <input type="checkbox"/> Depression _____      |
| <input type="checkbox"/> Shortness of breath _____         | <input type="checkbox"/> Gallbladder disease _____          | <input type="checkbox"/> Gout _____            |
| <input type="checkbox"/> Heart palpitations _____          | <input type="checkbox"/> Prostate disease _____             | <input type="checkbox"/> Scarlet fever _____   |
| <input type="checkbox"/> Heart murmur _____                | <input type="checkbox"/> Bowel irregularity _____           | <input type="checkbox"/> Chronic rashes _____  |
| <input type="checkbox"/> Chest pain _____                  | <input type="checkbox"/> Incontinence _____                 | <input type="checkbox"/> Rheumatic fever _____ |
| <input type="checkbox"/> Dizziness/Fainting _____          | <input type="checkbox"/> Sexual/menstrual dysfunction _____ | <input type="checkbox"/> Mumps _____           |
| <input type="checkbox"/> Peripheral vascular disease _____ | <input type="checkbox"/> Venereal disease _____             | <input type="checkbox"/> Measles _____         |
| <input type="checkbox"/> Allergies/Hay fever _____         | <input type="checkbox"/> Frequent infections _____          | <input type="checkbox"/> Rubella _____         |
| <input type="checkbox"/> Asthma _____                      | <input type="checkbox"/> Hepatitis _____                    | <input type="checkbox"/> Polio _____           |
| <input type="checkbox"/> Bronchitis _____                  | <input type="checkbox"/> Anemia _____                       | <input type="checkbox"/> Diphtheria _____      |
| <input type="checkbox"/> Pneumonia _____                   | <input type="checkbox"/> Arthritis _____                    | <input type="checkbox"/> Tetanus _____         |
| <input type="checkbox"/> Ulcer _____                       | <input type="checkbox"/> Osteoporosis _____                 | <input type="checkbox"/> Other _____           |
| <input type="checkbox"/> GI disorder _____                 | <input type="checkbox"/> Nervousness _____                  | <input type="checkbox"/> Other _____           |

**HABITS**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Smoke: Packs daily _____<br>How long? _____<br>Interested in stopping? _____ | <input type="checkbox"/> Coffee: Cups daily _____<br>Other caffeine _____ | <input type="checkbox"/> Sleep: Difficulty falling asleep _____<br>Continuity disturbances _____<br>Snoring _____<br>Early morning awakening _____<br>Daytime drowsiness _____<br>Other _____ |
| <input type="checkbox"/> Exercise routine: _____  | <input type="checkbox"/> Alcohol: Type _____<br>Amount _____              |   |
|   | <input type="checkbox"/> Diet: Salt intake _____<br>Fat intake _____      |   |

**Hepatitis C risk factor**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Blood transfusion prior to 1992 | <input type="checkbox"/> Contact with blood/bodily fluid | <input type="checkbox"/> Shared razor/toothbrush |
| <input type="checkbox"/> IV drug use (1+ times)          | <input type="checkbox"/> Tattoos                         | <input type="checkbox"/> Body piercing           |

**Levaquin**<sup>®</sup> Tablets  
Injection  
(levofloxacin tablets/injection)

Available in  
**250 mg tablets**

Please see accompanying full Prescribing Information.

Triple i / Cliniforms © 1999 FP011 800.969.7237

