

**INFORMATION FOR YOUR PHYSICIAN****HUDSON'S BAY MEDICAL GROUP**

Please answer the following questions prior to your f... exam. It will help your physician to know not only about your health but also your family &amp; relatives.

**100 E 33<sup>RD</sup> ST. SUITE 206  
VANCOUVER, WA 98663**

Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_ Today's Date: \_\_\_\_\_

D.O.B: \_\_\_\_\_ Age: \_\_\_\_\_ Place of Birth: \_\_\_\_\_ Race or Nationality of Parents: \_\_\_\_\_

Religion: \_\_\_\_\_ Education: \_\_\_\_\_ Occupation: \_\_\_\_\_ How long? \_\_\_\_\_

Present Marriage (years married): \_\_\_\_\_ Previous Marriage (years married &amp; duration) \_\_\_\_\_

Where &amp; When Have You Traveled Outside The US &amp; Canada? \_\_\_\_\_

Alive	Father	present health or cause of death	Mother	present health or cause of death	Spouse	present health or cause of death
Deceased	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
Brothers	No. Alive	Health	No. Deceased	Cause of Death		
Sister	No. Alive	Health	No. Deceased	Cause of Death		
Children	No. Alive	Health	No. Deceased	Cause of Death		

Circle illnesses which have occurred in any of your blood relatives: **Diabetes Cancer Bleeding Tendency Kidney Disease Tuberculosis Heart Disease Stroke High Blood Pressure Nervous Illness Allergy Other:**Circle any illnesses or conditions YOU have had: **Diabetes Glaucoma Heart Trouble Syphilis Vein Trouble Cancer Asthma Jaundice Gonorrhoea Bleeding Tendencies Tuberculosis Pneumonia Kidney Disease Rheumatic Fever Nervous Disorder Psychiatric Disease Other:**Circle & date the diseases against which you have been immunized:  
**Small Pox: Tetanus: Polio: Influenza: Pneumonia: Other:**

Previous Operations &amp; Dates: \_\_\_\_\_

List other illnesses not requiring operation for which you were hospitalized: \_\_\_\_\_

Have you had serious injuries, broken bones, etc.? List: \_\_\_\_\_

Have you had allergy or sensitivity to medicines or other substances? List: \_\_\_\_\_

Do you use Tobacco? In The Past? Type &amp; Daily Amount: \_\_\_\_\_ How Long? \_\_\_\_\_

Do you use Alcoholic Beverages? Type: \_\_\_\_\_ Weekly Amount: \_\_\_\_\_ How Long? \_\_\_\_\_

Do you Drink Coffee? \_\_\_\_\_ Weekly Amount: \_\_\_\_\_ How Long? \_\_\_\_\_

Dental (List any problems you have now): \_\_\_\_\_

Medications (Name &amp; Dose): \_\_\_\_\_

Have you taken cortisone type drugs? \_\_\_\_\_ Have you received a blood transfusion? \_\_\_\_\_

Dressed Weight: \_\_\_\_\_ How long have you been at this weight? \_\_\_\_\_ Oral Contraceptives? \_\_\_\_\_

What is your main medical problem &amp; how long have you had it? \_\_\_\_\_

Reviewed By (Physician): \_\_\_\_\_ Date: \_\_\_\_\_