

PATIENT IDENTIFICATION:

Name: (Last) _____ (First) _____ (MI) _____

DOB (MMDDYY): _____ Ethnicity: _____ Sex: M or F Religious Preference: _____

Duty Phone (with prefix): _____ Home Phone (with prefix): _____

Cell Phone: _____ Email Address: _____

Marital Status: (Married) (Divorced) (Single) How many children do you have? _____

APO/FPO/ CFPO Address: _____

SPONSOR'S INFORMATION

Social Security Number: _____ - _____ - _____ Unit Assigned To: _____

Rank: _____ Service: (Army) (Air Force) (Navy) (Marines) (DoD) (Other) _____

Duty Phone (with prefix): _____ Home Phone (with prefix): _____

To better assess your health, please indicate below if you have any significant medical problems or concerns:

- | | | | | | |
|---------------|---------------------|---------------|--------------|------------------|----------|
| Asthma | Abnormal Bleeding | Allergies | Diabetes | Drug Allergies | Epilepsy |
| Heart Disease | High Blood Pressure | Latex Allergy | Lung Disease | Venereal Disease | |

Others: _____

Please list any previous surgical procedures and dates: _____

Please list all medications you are presently taking: See LRMC Memo 40-51 Medication Reconciliation Patient Questionnaire

List all prescription medications you are presently taking: See LRMC Memo Outpatient Medication Reconciliation Patient Questionnaire

Please list previous hospitalizations: _____

Do you or have you ever smoked: Y or N If yes, please circle: (cigarettes) (cigar) (pipes) (other): _____

How much? _____ How much daily? _____ How many years? _____

Do you drink alcohol? Y or N If yes, how much? _____ How often? _____

Do you drink caffeine? Y or N If yes, how much weekly? _____

List any medical problems that run in your family history: _____

FEMALE ONLY: How many times have you been pregnant? _____ How many miscarriages have you had? _____