Stewart Hill Tankersley, M.D.

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Do you have any drug allergies? No ☐ Yes ☐ Please list ______________________________

Are you allergic to : Aspirin ☐ Penicillin ☐ Local Anesthetics ☐ Acrylic ☐ Latex ☐ Iodine ☐ Other ☐: ______________________________

Current Medications: ______________________________

____

WOMEN ONLY Are you pregnant? No ☐ Yes ☐ Are you planning a pregnancy? No ☐ Yes ☐ Last gynocological exam: _____/_____/__________

HOSPITALIZATION OR SURGERY

REASON	DATE	REASON	DATE

FAMILY MEDICAL HISTORY

FAMILY MEDICAL HISTORY	FAMILY MEMBER DIAGNOSED	FAMILY MEDICAL HISTORY	FAMILY MEMBER DIAGNOSED	FAMILY MEDICAL HISTORY	FAMILY MEMBER DIAGNOSED
Heart Disease		Cancer		Kidney Disease	
High Blood Pressure		Diabetes		Liver Disease	
Stroke		Epilepsy or Convulsions		Thyroid Disease	
Glaucoma		Mental Illness		Other:	

MEDICAL HISTORY

Please check yes or no for each item	YES	NO	Please check yes or no for each item	YES	NO	Please check yes or no for each item	YES	NO	Please check yes or no for each item	YES	NO
Anemia			Emphysema			Heart Pacemaker			Renal Dialysis		
Angina			Epilepsy / Seizures			Heart Disease			Rheumatic Fever		
Anxiety			Excessive Bleeding			Hepatitis A			Scarlet Fever		
Arthritis / Gout			Excessive Thirst			Hepatitis B or C			Sexual/Menstrual Dysfunction		
Asthma			Fainting / Dizziness			Herpes			Shingle		
Blood Disease			Frequent Cough			High Blood Pressure			Shortness of Breath		
Blood Transfusion			Frequent Diarrhea			High Cholesterol			Sickle Cell Disease		
Breathing Problems			Frequent Headaches			Hives or Rash			Sinus Trouble		
Cancer			Gall Bladder Disease			Irregular Heartbeat			Stomach/Intestinal Disease		
Chest Pains			Genital Herpes			Kidney Problems			Stroke		
Congenital Heart Disorder			GI Disorder			Liver Disease			Swelling		
Convulsions			Glaucoma			Lung Disease			Thyroid Disease		
Depression			Hay Fever / Allergies			Osteoporosis			Tonsilitis		
Diabetes			Heart Attack / Failure			Psychiatric Care			Ulcers		
Drug Addiction			Heart Murmur			Recent Weight Lose			Venereal Disease		

Other medical issue(s) not listed: ______________________________

☐ Smoking Current ☐ Quit ☐ When did you stop? __________ How many packs per day? _____ How long have you smoked? __________

☐ Alcohol Current ☐ Quit ☐ When did you stop? __________ How many drinks per day? _____

☐ Coffee How many cups day? _____ Any other Caffeines? ______________________________

Have you had the following vaccines? Hepatitis A ☐_____ Hepatitis B ☐_____ Influenza ☐_____ MMR ☐_____ Pneumonia ☐_____ Shingles ☐_____ Tetanus ☐_____ Tdap ☐_____

Last Name: __________________ First Name: __________________ Middle Initial: _____ DOB: _____/_____/__________

Patient Signature: ______________________________ **Date:** _____/_____/__________