Urban Family Practice 564 Niagara Street Buffalo, New York 14201

Name _____ Age _____ Birthdate _____ Today's Date _____

1. What are you being seen for today? _____
2. When did the problem begin? _____
3. List **ANY** old injuries and brief description of how they happened. _____

_____

4. Have you had **ANY** previous surgery at any time in your life? Yes ☐ No ☐ If yes, list here: _____

_____

_____

5. Have you seen a physician for any reason in the past year? _____

   If so, for what. _____

_____

6. List doctors you have seen within the last year. _____
7. Occupation & Description. _____
8. Are you ☐ Right handed ☐ Left handed?
9. Are you taking any prescribed or over the counter medication? Yes ☐ No ☐ If yes, list drug & dosage here (use reverse side if needed): _____

_____

_____

10. ARE YOU ALLERGIC TO ANY MEDICATION? Yes ☐ No ☐ If yes, what was drug and your reaction _____

_____

11. Is there any history of diseases in your family? Yes ☐ No ☐ If yes, please Circle the appropriate diseases and describe.

    Diabetes Hypertension Heart Kidney Cancer

_____

12. Have you had any problems in anyway related to the following? If so, please check and **GIVE DETAILS ON THE BACK OF THIS FORM.**

Sinus Infection	Yes ___	No ___	Chest Pain	Yes ___	No ___	Hepatitis	Yes ___	No ___
Eye Problems	Yes ___	No ___	Shortness of Breath	Yes ___	No ___	Liver Disease	Yes ___	No ___
Nose Bleeds	Yes ___	No ___	Ankle Swelling	Yes ___	No ___	Kidney or Bladder Problems	Yes ___	No ___
Headache	Yes ___	No ___	Blood Clots / Phlebitis	Yes ___	No ___	Seizures	Yes ___	No ___
T.B.	Yes ___	No ___	High Blood Pressure	Yes ___	No ___	Paralysis	Yes ___	No ___
Valley Fever	Yes ___	No ___	Ulcers	Yes ___	No ___	Diabetes	Yes ___	No ___
Asthma	Yes ___	No ___	Indigestion	Yes ___	No ___	Thyroid	Yes ___	No ___
Emphysema	Yes ___	No ___	Change in Bowel Habits	Yes ___	No ___	Cancer	Yes ___	No ___
Heart Disease	Yes ___	No ___	Bloody or Tarry Stools	Yes ___	No ___			

13. Do you smoke? Yes ☐ No ☐ How much? _____ Do you drink alcohol? Yes ☐ No ☐ How much? _____
14. CURRENT HEIGHT _____ WEIGHT _____
15. Do you use drugs (Marijuana, LSD, Heroin, Cocaine)? Yes ☐ No ☐ If yes, please circle which one.
16. Are you pregnant? Yes ☐ No ☐ Expected delivery date: _____

FORM #64-Y (Rev. 7/03)

_____
Signature (Parent or legal guardian)