Andy Fine, M.D., P.C.

Patient Name DOB Drug allergies:

Do you, or any blood relatives, have any of the following? (& who?)

	You this column	**Family in this Column** (living or deceased)
Diabetes		
High Blood Pressure		
Elevated Cholesterol		
Heart Disease / Heart Attack		
Strokes		
Depression		
Anxiety		
Thyroid Disorders		
Respiratory Problems (& type)		
Cancer (& type)		
Neurological Problems		
Any Additional Diagnoses		

Name & Age of:Mother Father

Siblings

Please list your medications:
(or provide list)

Do You:	**Now**	**History (start & end dates)**
Exercise Regularly?(what?)		Frequency?
Follow A Particular Diet?		Which?
See a Doctor Regularly?		
Use Tobacco?		Amount?
Alcohol Consumption		Amount?
Illicit Drug Use		Amount?
Have Hobbies?		What?
Work?		Doing What?

Please list your other physicians:

Your Surgical History:

Please provide the month & year (or approximate) of your last:

Tetanus vaccine (Or, was it within the last 8 yrs?)**:** **Pneumonia vaccine** (within the last 5 yrs?)**:**

Physical: **Mammogram:** **Ever abnormal?** **/ Pap Smear:** **Ever abnormal?**

Bone Density Study: **Findings?** **Next due?** **/ Stress Test:** **Findings?**

Colonoscopy: **Findings?** **Next due?** **/ Other:**

Purpose of today's visit: