Mercy Physicians Group-Family Practice
4400 Flamingo Ave E, Suite 301 Nampa, ID 83687-9203

Date: _____/____/____
Name:_____ Name you prefer to be called: _____
Date of Birth:_____ Phone number: (home)_____(other)_____
Pharmacy preference:_____Occupation:_____

Allergies:
Please list all allergies including medication, food, and other allergens with reaction

Allergy	**Reaction**	**Immunizations**
_____	_____	**Last Tetanus:**_____
_____	_____	**Last Pneumovax:**_____
_____	_____	**Childhood**
_____	_____	

Family History:
Please list any significant family history and the relation of the person.
_____
_____
_____
_____

Social History:
Tobacco use: Have you ever smoked or dipped tobacco? Y/N Year started_____
How much do you smoke/dip a day?_____
Have you quit? Y/N If yes, when?(year)_____

Alcohol use: Do you consume alcohol? Y/N
If yes, how often to you drink? Daily Weekly Monthly Yearly
How many drinks do you consume when drinking? _____

Drug Use: Have you ever used illicit drugs (illegal drugs)? Y/N
If yes, which drugs have you used?_____

Medications:
Please list *ALL* medications (prescription, over the counter, and vitamin/supplements) that you are currently taking.

Medication	**Dose**	**How often?**	**When did you start taking this?**

Past Medical History:

Have you had any of the following:			*Details of illness and date illness began*
Heart Disease	**Y**	**N**	_____
High Blood Pressure	**Y**	**N**	_____
Cancer	**Y**	**N**	_____
Diabetes	**Y**	**N**	_____
Lung Disease (asthma,etc)	**Y**	**N**	_____
Hepatitis	**Y**	**N**	_____
Digestive/Bowel Problems	**Y**	**N**	_____
Seizures	**Y**	**N**	_____
Headaches	**Y**	**N**	_____
Thyroid Disease	**Y**	**N**	_____
Skin problems	**Y**	**N**	_____
Blood disorders(anemia,etc)	**Y**	**N**	_____
Autoimmune disease	**Y**	**N**	_____
Chronic Fatigue	**Y**	**N**	_____
Depression	**Y**	**N**	_____
Urinary Problems	**Y**	**N**	_____

Other:_____

_____

For women:

Number of pregnancies:_____ **Age of first menstrual cycle:**_____

History of difficult menstruation	**Y**	**N**	_____
Have you begun menopause	**Y**	**N**	_____

For men:

Erectile dysfunction	**Y**	**N**	_____
Difficulty urinating	**Y**	**N**	_____

Surgical History:

Please list any surgeries that you have had in the past and the year that they were performed:

_____

_____

_____

_____

Please sign and date below:

_____

Patient signature **Date**