Dr. Anne Marie Palzer

PATIENT MEDICAL HISTORY Date: _____

First Name: _____ Last Name: _____

Address: _____ Date of Birth: _____

City: _____ State: _____ Zip: _____

Phone (h): _____ Cell Phone: _____

Email: _____

As these are not generally considered secure and private communication devices, please let us know:

Is it acceptable to contact you via email? Yes No

Is it acceptable for us to leave a message on a voice mail/answering machine for you? Yes No

Occupation: _____

Employer's Name: _____

How were you referred? _____

Social Security Number: _____

If under 18, parent or guardian name(s): _____

Emergency Contact Name: _____ Phone number: _____

Gender: _____ Marital Status: _____

Height: _____ Weight: _____

Last physical exam: _____

Are all vaccines current? Yes No

If your vaccines are not current, have you elected to decline vaccination or selectively choose which vaccines to have? _____

Last Chest X-ray: _____ Last Blood Test: _____

Last Eye Examination: _____ Last Dental Visit: _____

If 18 or older, when was your last:

Pneumonia vaccine_____ Tetanus booster _____ Flu vaccine _____

Any other diagnostic tests in the last 3 years: Yes No

If yes what, when and the results?

_____

If 17 or younger, last well child exam: _____

If male, last prostate exam and/or PSA level:

If female, last Gynecological exam with: Pap test \ physical exam \ breast exam \ mammogram

Do you do self breast exams regularly? Yes No