

Lehigh Valley Family Practice  
 1401 Fairmont Street  
 Whitehall, PA 18052  
 610-432-4122

PATIENT DATA BASE

DATE

|   |  |   |   |                    |                      |                   |               |                 |               |                  |            |              |              |
|---|--|---|---|--------------------|----------------------|-------------------|---------------|-----------------|---------------|------------------|------------|--------------|--------------|
| <b>PERSONAL DATA</b>  | Name _____ Birthdate _____<br><br>Allergies _____  |   |   |                    |                      |                   |               |                 |               |                  |            |              |              |
| <b>MEDICAL HISTORY</b>  | <table style="width: 100%; border: none;"> <tr> <td style="width: 25%;">High Blood Pressure Y N</td> <td style="width: 25%;">Eye Disease Y N</td> <td style="width: 25%;">Kidney Disease Y N</td> <td style="width: 25%;">Poor Circulation Y N</td> </tr> <tr> <td>Heart Disease Y N</td> <td>Arthritis Y N</td> <td>G I Disease Y N</td> <td>Allergies Y N</td> </tr> <tr> <td>Lung Disease Y N</td> <td>Cancer Y N</td> <td>Seizures Y N</td> <td>Diabetes Y N</td> </tr> </table>   | High Blood Pressure Y N   | Eye Disease Y N   | Kidney Disease Y N | Poor Circulation Y N | Heart Disease Y N | Arthritis Y N | G I Disease Y N | Allergies Y N | Lung Disease Y N | Cancer Y N | Seizures Y N | Diabetes Y N |
| High Blood Pressure Y N   | Eye Disease Y N  | Kidney Disease Y N  | Poor Circulation Y N  |                    |                      |                   |               |                 |               |                  |            |              |              |
| Heart Disease Y N   | Arthritis Y N  | G I Disease Y N   | Allergies Y N   |                    |                      |                   |               |                 |               |                  |            |              |              |
| Lung Disease Y N  | Cancer Y N   | Seizures Y N  | Diabetes Y N  |                    |                      |                   |               |                 |               |                  |            |              |              |
|   | Other Y N (describe) _____<br>Hospitalization Y N (describe) _____<br>Surgery Y N (describe) _____   |   |   |                    |                      |                   |               |                 |               |                  |            |              |              |
| <b>FAMILY HISTORY</b>   | List Medical history/problems and comment state of health for each: <ul style="list-style-type: none"> <li>• Mother _____</li> <li>• Father _____</li> <li>• Brothers _____</li> <li>• Sisters _____</li> </ul>  |   |   |                    |                      |                   |               |                 |               |                  |            |              |              |
| <b>SOCIAL HISTORY</b>   | DO you use:<br>Tobacco Y N    What form: _____ How often: _____ Duration: _____<br>Alcohol Y N    How often: _____ Duration: _____<br>Other Substances/<br>Drugs    How often: _____ Duration: _____<br>What type of drugs: _____  |   |   |                    |                      |                   |               |                 |               |                  |            |              |              |
| <b>HABITS</b>   | <table style="width: 100%; border: none;"> <tr> <td style="width: 50%; vertical-align: top;"> <input type="checkbox"/> Exercise Routine: _____<br/> <input type="checkbox"/> Contact with blood/bodily fluid at work/ otherwise _____           </td> <td style="width: 50%; vertical-align: top;">             Coffee: Cups daily _____<br/>             Difficulty Sleeping:<br/>             Disturbance while sleeping<br/>             Do you snore?<br/>             Daytime Drowsiness           </td> </tr> </table> | <input type="checkbox"/> Exercise Routine: _____<br><input type="checkbox"/> Contact with blood/bodily fluid at work/ otherwise _____ | Coffee: Cups daily _____<br>Difficulty Sleeping:<br>Disturbance while sleeping<br>Do you snore?<br>Daytime Drowsiness |                    |                      |                   |               |                 |               |                  |            |              |              |
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| <b>MEDICATIONS</b>  | List all medication/dose you are currently taking: <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1. _____</td> <td style="width: 50%;">4. _____</td> </tr> <tr> <td>2. _____</td> <td>5. _____</td> </tr> <tr> <td>3. _____</td> <td>6. _____</td> </tr> </table>  | 1. _____  | 4. _____  | 2. _____           | 5. _____             | 3. _____          | 6. _____      |                 |               |                  |            |              |              |
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| 2. _____  | 5. _____   |   |   |                    |                      |                   |               |                 |               |                  |            |              |              |
| 3. _____  | 6. _____   |   |   |                    |                      |                   |               |                 |               |                  |            |              |              |
| <b>VACCINATIONS</b>   | Please Provide a copy of childhood immunization records for pediatric patients. List all immunizations your child has already received and the date they were given <table style="width: 100%; border: none;"> <tr> <td style="width: 50%;">1. _____</td> <td style="width: 50%;">4. _____</td> </tr> <tr> <td>2. _____</td> <td>5. _____</td> </tr> <tr> <td>3. _____</td> <td>6. _____</td> </tr> </table>   | 1. _____  | 4. _____  | 2. _____           | 5. _____             | 3. _____          | 6. _____      |                 |               |                  |            |              |              |
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