Gulf Shores General Practice Center
The Key to Your Health Care Success
Gregory Funk, D.O.

WELCOME TO OUR PRACTICE

PATIENT NAME: _____ TODAYS DATE: _____

DATE OF BIRTH: _____ AGE: _____ FEMALE: _____ MALE: _____

PATIENT HEALTH HISTORY

ALLERGIES: DRUG FOOD

_____ _____

_____ _____

MEDICATIONS: **(LIST MEDICATIONS YOU ARE CURRENTLY TAKING, INCLUDING EYE DROPS)**

MEDICATION:	**START DATE:**	**NAME OF PRESCRIBING PHYSICIAN:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

SURGERIES / DATES PERFORMED:

_____

_____

SOCIAL HISTORY:

NUMBER OF PREGNANCIES_____ NUMBER OF DELIVERIES_____NUMBER OF LIVING CHILDREN____

DO YOU SMOKE? YES NO # OF PACKS PER DAY _____ # OF YEARS _____

HAVE YOU PREVIOUSLY SMOKED? YES NO #OF PACKS PER DAY _____ # OF YEARS _____

DO YOU TAKE TWO OR MORE ALCOHOLIC DRINKS PER DAY? YES NO # OF DRINKS_____

HOW MANY CUPS OF COFFEE/TEA DO YOU DRINK A DAY? _____

HAVE YOU USED STREET DRUGS BEFORE? YES NO
IF YES LIST_____
DO YOU USE STREET DRUGS NOW? YES NO
IF YES LIST:_____

HEALTHY DIET? YES NO
WHAT PHYSICAL EXERCISE DO YOU PARTICIPATE IN? _____
DO YOU HAVE PROBLEMS WITH SLEEP PATTERNS? YES NO
DO YOU HAVE PROBLEMS WITH CONSTIPATION? YES NO
DO YOU HAVE PROBLEMS WITH DIARRHEA? YES NO