Dr. Tommy R. Thompson
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Lawrenceburg, IN 47025
(812) 577-0289

Patient Information

Date: ________________
Name: ___________________ SS#: ____________________ Phone#: ____________________
Address: ____________________________ City: ________________ State: _____ Zip: __________
E-mail: _________________________ Age: _____ Birth Date: __________________
Marital Status: M S W D Occupation: ____
How many children? ____ Ages of Children: ________________________________
Name of Nearest Relative: ___________________________________ Phone#: _____________________
How were you referred to our office? ____

History of Present Illness:
Chief Complaint (purpose of this appt): ____
Date symptoms appeared: __________ Is this due to: Auto __ Work __ Other __
Have you ever had the same or similar condition? Y N When? _____________________
Date of last physical examination: ____________________________________

Past Medical History:
Have you been diagnosed as having or have suffered from?

__ broken/fractured bones
__ circulatory problems
__ rheumatoid arthritis
__ seizures/convulsions
__ congenital disease
__ excessive bleeding
__ high/low blood pressure
__ osteoarthritis
__ epilepsy
__ pacemaker
__ strokes
__ cancer
__ ruptures
__ coughing blood
__ eating disorder
__ alcoholism
__ drug addiction
__ HIV positive
__ gall bladder
__ depression
__ ulcers

Do you have a history of stroke or hypertension? Y N Have you had any major illnesses, injuries, falls, auto accidents, or surgeries? Women, include childbirth. Include dates: _______________
____
Have you been treated for any health condition by a physician in the last year? Y N
If yes, describe: ____
What medications or drugs are you taking? ____
Do you have allergies to any medications? Y N If yes, describe: ___________________________________
Do you have allergies of any kind? Y N If yes, describe: ____

Do you have any scars? Y N If yes, where and cause: ____
Did you have wisdom teeth removed? Y N If yes, how many? ___________
Please list any other health concerns you have, no matter how insignificant it can be: _______________
____

Social History:
Do you drink alcoholic beverages? Y N If so, how much per week? ______________________
Do you use tobacco products? Y N Do you smoke? Y N If so, how many packs/day? _______
Do you take vitamin supplements? Y N If so, list: ___________________________________
How much caffeine do you consume per day? ______________________________
Do you exercise? Y N If yes, frequency and type of exercise: ____________________________
What are your hobbies? ____
What percentage during the day do you spend:
Lifting ____ % Sitting ____ % Bending ____ % Working at computer ____ %

Family History:
Father: Living ___ Age ____ Deceased ____ Cause/age of death __________________
Mother: Living ____ Age ____ Deceased ____ Cause/age of death __________________
Check if applicable to you ___ As an adopted child, little is known of birth parents/family
Do you have family members that suffer from same condition as you? Y N If so,
list: ____

Family Diseases: (mark M, F, S, B for mother, father, sister, brother)
____ tuberculosis
____ cancer
____ mental illness
____ diabetes
____ asthma
____ heart disease
____ stroke
____ kidney disease
____ lung disease
____ arthritis
____ liver disease
Other ____

For Females:
Do you have regular or missed periods? ____________________ How many days do they last? ____
How many days between cycles? ______
Do you experience cramps, bloating, or PMS? _____________________________
Do you experience a light, normal, or heavy flow? __________________________