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INFORMATION FOR YOUR PHYSICIAN

Complete BOTH SIDES in blue or black ink only

Bay Street MEDICAL
LIVING ON THE HEALTHIER SIDE OF LIFE

Please answer the following questions. It will help your physician to know not only about your health but also about your family and relatives.

Patient Name _____ Clinic Number _____
Today's Date _____ Current Age _____ Place of Birth _____
Race or nationality of parents _____
Are you employed? ☐ Yes ☐ No ☐ Retired If yes, what is your occupation? _____
Have you traveled outside of The Bahamas in the past 5 years? ☐ Yes ☐ No If yes, where? _____

	LIVING	PRESENT AGE OR AGE AT DEATH	Significant health problems or cause of death
Father	☐ Yes ☐ No	_____	_____
Mother	☐ Yes ☐ No	_____	_____
Spouse/Domestic Partner	☐ Yes ☐ No	_____	_____

Present marriage/relationship (years) _____ Previous marriage(s)/relationship(s)(years) _____

Brothers	Number living	_____	Significant health problems	_____
	Number non-living	_____	Cause(s) of death	_____
Sisters	Number living	_____	Significant health problems	_____
	Number non-living	_____	Cause(s) of death	_____
Children	Number living	_____	Significant health problems	_____
	Number non-living	_____	Cause(s) of death	_____

Have there been any changes since your last examination? ☐ Yes ☐ No Explain _____

Please check illnesses which have occurred in any of your blood relatives:

☐ Bleeding tendencies ☐ Diabetes ☐ High blood pressure ☐ Nervous disease
☐ Cancer ☐ Heart disease ☐ Kidney disease ☐ Stroke

Please check illnesses or conditions which you have had:

☐ Asthma ☐ Bleeding tendencies ☐ Cancer ☐ Diabetes
☐ Glaucoma ☐ HIV ☐ Heart trouble ☐ Hepatitis
☐ High blood pressure ☐ Jaundice ☐ Kidney disease ☐ Nervous disorder
☐ Pneumonia ☐ Rheumatic fever ☐ Stroke/TIA ☐ Tuberculosis
☐ Hypothyroidism ☐ Sleep apnea ☐ Reflux/peptic ulcer disease ☐ Blood clots
☐ Obesity ☐ Elevated cholesterol ☐ Other: _____

What type of physical activities do you perform (including Yoga, Aerobics, etc.)? _____
Do you engage in any other healing or alternative therapies (e.g. acupuncture, massage, hypnosis, etc.)? _____

Previous operations (please list procedure and year)

1. _____ 2. _____
3. _____ 4. _____
5. _____ 6. _____

Have you had any serious injuries, broken bones, etc.? ☐ Yes ☐ No
If yes, please list _____

Have you ever had an allergic reaction to any medications? ☐ Yes ☐ No
If yes, which medications and what type of reaction? _____

Have you ever had an allergic reaction to X-ray contrast dye? ☐ Yes ☐ No
If yes, please describe _____

Have you ever had a latex allergy? ☐ Yes ☐ No
Have you ever had a tape allergy? ☐ Yes ☐ No

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Tobacco use ☐ Never ☐ Now ☐ In the past How much each day? _____ For how many years? _____
When did you quit? _____

Alcohol use ☐ Never ☐ Now ☐ In the past How much each day? _____ For how many years? _____
When did you quit? _____

Recreational drug use ☐ Never ☐ Now ☐ In the past How much each day? _____ For how many years? _____
When did you quit? _____

Please check the diseases against which you have been immunized:

☐ Tetanus _____ DATE OF IMMUNIZATION
☐ Pneumovax _____ DATE OF IMMUNIZATION
☐ Hepatitis A ☐ Hepatitis B ☐ Zoster Vaccines
☐ Measles ☐ Polio ☐ HPV
☐ German measles (Rubella) ☐ Influenza

Prescription Medications	Dosage (mg)	Frequency (once, twice, etc., per day)

Non Prescription Medications (including over-the-counter drugs, supplements, herbs, vitamins, etc.)

Have you taken cortisone-type drugs? ☐ Yes ☐ No
Have you ever had blood products transfused? ☐ Yes ☐ No If yes, when? _____ where? _____
When was your most recent proctoscopic/sigmoidoscopic/barium enema/colonoscopic exam? _____
What is your usual weight? _____ How long have you been at this weight? _____

WOMEN ONLY

History of abnormal Pap smear? ☐ Yes ☐ No Last menstrual period _____ Last pap smear? _____
Most recent mamogram? _____ Periods are ☐ regular ☐ irregular
Number of Pregnancies _____ Number of miscarriages _____

Is there anything else you would like evaluated? **(PATIENT TO INCUR ADDITIONAL COST)**

☐ No, I do not want any other conditions addressed.

_____
_____
_____
_____
_____
_____

Non-Bay Street Medical physician involved in your care:

Name _____
Address _____
City _____ State _____ Zip Code _____

In order to support your continuing care, Bay Street Medical may share a summary of your findings with the above listed physician.