GRANGER MEDICAL CLINIC

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Granger Medical Clinic

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West Jordan, UT 84088
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Patient History Form

Patient's Name (Last) (First) (M.I.)			Sex (F,M)	Today's Date:
Date of Birth:	Age:	Primary Phone #	Marital Status(single, married, divorced, widowed)	
Spouses Name:			Contact Number:	

Medications	Dose	Reason for Medication	Side Effects

ALLERGIES:	Shoe Size:
Family Physician: Phone#	Are you currently under physician care? Yes No For What?
Who may we thank for referring you to our office?	**Family History** (Circle) Diabetes Y N Seizures Y N Bleeding Disorders Y N Hypertension Y N Foot Disorders Y N

Your Medical History (Circle)	Past Surgeries/Hospitalizations: Date:
Y N Cancer	
Y N Diabetes	
Y N Hypertension	
Y N Bleeding Disorder/Anemia	
Y N Gastric Ulcers	
Y N Gout	
Other	

Have you ever had general anesthesia? YES NO	Any Complication from Anesthesia? YES NO

Social History:
Tobacco Yes No Alcohol Yes No Illicit Drugs Yes No
Sports/Activities?

Please describe the reason for your visit today: Date of onset:

Rate your pain from 1-10: _____

Signature: Date: