OSFP Form 9
Sep 2000

INFORMATION FOR YOUR PHYSICIAN

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

TODAY'S DATE

NAME | ADDRESS

TELEPHONE NUMBER | DATE OF BIRTH | AGE | PLACE OF BIRTH | RACE OR NATIONALITY OF PARENTS

RELIGION | EDUCATION (Highest level attained) | OCCUPATION ► | HOW LONG

PRESENT MARRIAGE (Year married) | PREVIOUS MARRIAGE (Year married and duration)

WHERE AND WHEN HAVE YOU LIVED OR TRAVELED OUTSIDE THE U.S. AND CANADA?

ALIVE ► DECEASED ►	FATHER ☐ ☐	Present health or cause of death	MOTHER ☐ ☐	Present health or cause of death	SPOUSE ☐ ☐	Present health or cause of death
BROTHERS ►	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH		
SISTERS ►	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH		
CHILDREN ►	NO. ALIVE	AGES & HEALTH	NO. DECEASED	AGES & CAUSE OF DEATH		

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES** ☐ Diabetes ☐ Cancer ☐ Bleeding tendency ☐ Kidney disease ☐ Tuberculosis ☐ Heart disease ☐ Stroke ☐ High blood pressure ☐ Nervous illness ☐ Allergy ☐ Other

CHECK ANY ILLNESSES OR CONDITIONS **YOU** HAVE HAD ☐ Diabetes ☐ Glaucoma ☐ Heart trouble ☐ Syphilis ☐ Vein trouble ☐ Cancer ☐ Asthma ☐ Jaundice ☐ Gonorrhea ☐ Bleeding tendencies ☐ Tuberculosis ☐ Pneumonia ☐ Kidney disease ☐ Rheumatic fever ☐ Nervous disorder ☐ Other

LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC.?
☐ No ☐ Yes ► LIST:

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES?
☐ NO ☐ Yes ► LIST:

DO YOU USE TOBACCO NOW? ☐ No ☐ Yes	IN THE PAST? ☐ No ☐ Yes	TYPE AND DAILY AMOUNT	HOW LONG?
DO YOU USE ALCOHOLIC BEVERAGES? ☐ No ☐ Yes ►	TYPE	WEEKLY AMOUNT	HOW LONG?
DO YOU DRINK COFFEE? ☐ No ☐ Yes ►		WEEKLY AMOUNT	HOW LONG?

CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED
☐ Smallpox ☐ Tetanus ☐ Typhoid ☐ Polio ☐ Influenza ☐ Other

PREVIOUS OPERATIONS (Dates, hospitals and name of surgeon)

DENTAL (List any problems you have now)

MEDICATIONS (Name or otherwise identify medicines now or recently used)

ONSET DATE OF LAST MENSTRUAL PERIOD	PERIODS ARE ☐ Regular ☐ Irregular	NUMBER OF PREGNANCIES	NUMBER OF MISCARRIAGES

HAVE YOU TAKEN CORTISONE-TYPE DRUGS? ☐ No ☐ Yes	ORAL CONTRACEPTIVES? ☐ No ☐ Yes	HAVE YOU RECEIVED A BLOOD TRANSFUSION? ☐ No ☐ Yes ► DATE:

DRESSED WEIGHT | HOW LONG HAVE YOU BEEN AT THIS WEIGHT?

WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT?

WHAT IS YOUR MAIN SYMPTOM?

REVIEWED BY (Physician) | DATE