Southwest Family Physicians, Inc. **COMPREHENSIVE CARE DATA SHEET** Date:___/___/_____

Last name:_____________________ First:_____________ Middle:_________ D.O.B.___/___/______ Sex: F M
Address:_______________________________ City:____________________ Zip:______
Home Phone:(____) ___-_____ Work Phone:(____) ___-_____ Cell:(____) ___-_____
Email:____ Occupation:____________________________

Medications which you are unable to take:____

Please list all your surgeries (tonsillectomy, appendectomy, etc.)			
Year	Surgery	Reason	Results

Please list serious illnesses you have had in the past or now have (diabetes, heart disease, high blood pressure, etc.)			
Year of onset	Illness	Current Condition	Current doctor

Please list current medications and supplements		
Name	Dose	What for

Personal history

Marital Status: Single Married Separated Divorced Widowed
Ages of any children:____________________________________
Highest level of education: _______________

Federally Required Questions. These will have no affect on the quality of care we provide you.
Primary language:________________
Race: Declined/Unknown White Black/African American Other
American Indian/Alaska Native Native Hawaiian/Pacific Islander
Ethnicity: Declined/Unknown Spanish/Hispanic Not Spanish/Hispanic