Lourdes Wellness Center

Integrative Family Medicine
Ronald P. Ciccone, M.D.
Medical Director

A Department of Our Lady of Lourdes Health System,
A Ministry of the Franciscan Sisters of Allegany, NY

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Patient History

Patient Name:_____ Date:_____

Please list any medicine, drugs or vitamins that you take:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Do you take birth control pills? ☐ Yes ☐No Which One?_____

Have you had an alcoholic drink in the last 48 hours? ☐Yes ☐No

Please list allergies and other sensitivities:

_____
_____
_____
_____
_____
_____

List any medications or liquids that cause you a bad reaction:

_____
_____
_____
_____
_____

List any operations or serious illness that you've had which required hospitalization. (include any pregnancies)

Month/Year	Illness/Operation

Have you ever had any of the following:

		YES
TB (Tuberculosis) Skin Test		☐
Tetanus (lockjaw) Shots		☐
Mumps or Shots for Mumps		☐
Measles or Shots for Measles		☐
German Measles or Shots		☐
Pap Smear:	Date_____	☐
Chest X-Ray:	Date:_____	☐
Complete Medical Exam:	Date_____	☐
EKG (Electrocardiogram)	Date:_____	☐
Blood Tests	Date: _____	☐
Pneumovax(Pneumonia) Shot	Date:_____	☐
Flu Shots		

Have you had any problems with:

	YES	NO		YES	NO
Liver or Hepatitis	☐	☐	Sex	☐	☐
Lumps	☐	☐	Sinuses	☐	☐
Moles	☐	☐	Hearing	☐	☐
Swelling	☐	☐	Seeing	☐	☐
Stiff Joints	☐	☐	Smelling	☐	☐
Dizziness	☐	☐	Racing Heart	☐	☐
Balance	☐	☐	Extra Heart Beat	☐	☐
Appetite	☐	☐	Digestion	☐	☐
Sleeping	☐	☐	Weight Gain/Loss	☐	☐
Breathing	☐	☐	Mood/Feelings	☐	☐
Pains, Aches	☐	☐	Menstruation	☐	☐
Rash	☐	☐	Ankle Swelling	☐	☐
Broken Bones	☐	☐	Varicose Veins	☐	☐
Anemia	☐	☐	Weakness	☐	☐
Asthma	☐	☐	Frequent Colds	☐	☐
Hay Fever	☐	☐	Urine/Kidney/Bladder	☐	☐
Bleeding Tendencies	☐	☐	Rheumatism	☐	☐
Cancer/Tumor	☐	☐	Arthritis	☐	☐
Diabetes	☐	☐	Stroke	☐	☐
Epilepsy	☐	☐	Tuberculosis	☐	☐
Glaucoma	☐	☐	Ulcer	☐	☐
Gout	☐	☐	Stomach Trouble	☐	☐
Heart Trouble	☐	☐	Hernia	☐	☐
High Blood Pressure	☐	☐	Hemorrhoids	☐	☐
Headaches	☐	☐	Thyroid Disease	☐	☐
Do you smoke?	☐	☐	Bowel Movement	☐	☐
How much:_____			Venereal Disease	☐	☐
Do you drink alcohol	☐	☐	Drink Coffee/Tea	☐	☐
How much:_____			How much:_____		

Will Dr. Ciccone be your Primary Care Physician?

☐Yes ☐Not Sure ☐No

If no, who is your Primary Care Physician?

_____