|  |  |
| --- | --- |
| Patient Name: | Today’s Date: / / |
| Social Security Number: - - | Date of Birth: / / |
| Previous Physician Name: | Date of Last Exam: / / |

|  |  |  |
| --- | --- | --- |
| **Section A: Past Medical History** | | |
| Please list hospitalizations: | Reason | Year |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| Please list your past surgeries: | Year |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

|  |
| --- |
| Please indicate your chronic medical problems by marking the appropriate box below: |
| □Heart disease/Murmur/Arrhythmia □Shortness of breath □Eye disorder/Glaucoma □Diabetes □High cholesterol □Asthma  □Seizures □Kidney/Bladder problems □High blood pressure  □Low blood pressure □Stroke □Arthritis  □Lung problems Type:\_\_\_\_\_\_\_\_\_ □Sinus problems □Headaches/Migraines □Heartburn/reflux □Seasonal allergies □Depression/Anxiety □Cancer Type: \_\_\_\_\_\_\_\_\_\_\_ □Anemia or blood problems □Tonsillitis  □Neurological Type:\_\_\_\_\_\_\_\_\_ □Ulcers/colitis □Swollen ankles  □Liver problems Type: \_\_\_\_\_\_\_\_ □Thyroid problems □Ear problems  □Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **Section B: Medications-** Please list your current medications, including non-prescription medications, vitamins and herbal supplements: | | |
| **Medication** | **Dose/Strength** | **Frequency/How often** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

|  |  |
| --- | --- |
| **Section C: Allergies-** Are you allergic to any medications? □Yes □No If yes, please list the reaction | |
| **Medication** | **Reaction** |
|  |  |
|  |  |

|  |
| --- |
| **Section D: Social History** |
| Tobacco □Yes □No \_\_\_\_\_\_\_\_ packs per day? If no, have you in the past? □Yes □No  Number of years? \_\_\_\_\_\_ Year Quit? \_\_\_\_\_  Alcohol □Yes □No \_\_\_\_\_\_\_\_drinks per week? If no, have you in the past? □Yes □No  Caffeine □Yes □No \_\_\_\_\_\_\_\_ cups per day?  Street Drugs □Yes □No  Do you exercise daily/weekly? □Yes □No Type: \_\_\_\_\_\_\_  Low fat diet? □Yes □No Type: \_\_\_\_\_\_\_  Do you have any pets? □Yes □No Type: \_\_\_\_\_\_\_  Number of Children: \_\_\_\_ Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

|  |  |
| --- | --- |
| **Section E: Procedures** (list year of last): Year | |
| Colonoscopy/Endoscopy |  |
| Stress Test/ECHO/EKG |  |

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |
| --- | --- | --- | --- |
| **Section F: Family History** | | | |
| Living Age (or age at death) List serious illnesses | | | |
| Mother: | □Yes □No |  |  |
| Father: | □Yes □No |  |  |
| Sister: | □Yes □No |  |  |
| Sister: | □Yes □No |  |  |
| Sister: | □Yes □No |  |  |
| Brother: | □Yes □No |  |  |
| Brother: | □Yes □No |  |  |
| Brother: | □Yes □No |  |  |
| **Maternal Relatives** | |  |  |
| Grandmother: | □Yes □No |  |  |
| Grandfather: | □Yes □No |  |  |
| Aunt: | □Yes □No |  |  |
| Uncle: | □Yes □No |  |  |
| **Paternal Relatives** | |  |  |
| Grandmother: | □Yes □No |  |  |
| Grandfather: | □Yes □No |  |  |
| Aunt: | □Yes □No |  |  |
| Uncle: | □Yes □No |  |  |

|  |
| --- |
| **Section G: Females: Gynecological History** |
| Date of last menstrual cycle: \_\_\_/\_\_\_/\_\_\_\_\_ Contraception Type: \_\_\_\_\_\_\_\_\_\_\_  Pregnancies: \_\_\_\_\_\_ Live Births: \_\_\_\_\_ Miscarriages: \_\_\_\_\_ Abortions: \_\_\_\_\_\_\_  Date of last Pap Smear: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you had an abnormal Pap Smear: □Yes □No Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you had a sexually transmitted disease: □Yes □No Diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date of last mammogram: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mammogram results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Have you ever had a breast biopsy: □Yes □No Biopsy results: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Last Bone Density Scan: \_\_\_/\_\_\_/\_\_\_\_\_ Flushing/Menopausal Symptoms: □Yes □No |

|  |
| --- |
| **Section H: Males:** |
| Date of last: Rectal/Prostate exam \_\_\_/\_\_\_/\_\_\_\_ PSA (prostate blood test) \_\_\_/\_\_\_/\_\_\_\_\_ |

**By signing below, I hereby certify that to the best of my knowledge all the information furnished on this form is complete, true and accurate.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_**

**Patient/Legal Guardian Signature** (mm/dd/yyyy)