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

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| **Section A: Past Medical History** |
| Please list hospitalizations: | Reason | Year |
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| Please list your past surgeries: | Year |
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| 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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| **Section B: Medications-** Please list your current medications, including non-prescription medications, vitamins and herbal supplements: |
| **Medication** | **Dose/Strength** | **Frequency/How often** |
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| **Section C: Allergies-** Are you allergic to any medications? □Yes □No If yes, please list the reaction  |
| **Medication** | **Reaction** |
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| **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 □NoDo 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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

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

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| **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 |  |  |

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| **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 |

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| **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)