

Name: _____ Date: _____
 Birthdate: _____ Previous Primary Physician: _____
 Current Specialists: _____

Medications

Please list any medications with strength that you currently take regularly (including non-prescription)

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies

Please list any allergies to medications, foods or other

<u>Medication</u>	<u>Food</u>	<u>Other</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medical History

Illnesses/Conditions

Do you have or have you ever had any of the following:

	Year
_____ Anemia	_____
_____ Anesthesia complications	_____
_____ Anxiety	_____
_____ Arthritis	_____
_____ Asthma	_____
_____ Birth Defects	_____
_____ Cancer (type: _____)	_____
_____ Colitis	_____
_____ Concussion	_____
_____ Depression/Nervous Breakdown	_____
_____ Diabetes	_____
_____ Emphysema	_____
_____ Heart Attack/Heart Disease	_____
_____ High Blood Pressure	_____
_____ High Cholesterol	_____
_____ Kidney Disease	_____
_____ Liver Disease/Hepatitis	_____
_____ Migraine Headaches	_____
_____ Mitral Valve Prolapse/Murmur	_____
_____ Osteoporosis	_____
_____ Pneumonia	_____
_____ Rheumatic Fever	_____
_____ Seizure Disorder	_____
_____ Sexually Transmitted Disease	_____
_____ Stroke	_____
_____ Thyroid Disorder	_____
_____ Tuberculosis	_____
_____ Ulcer	_____

Surgical Procedures/Hospitalizations

Year

_____	_____
_____	_____
_____	_____

Childhood Diseases

Year

_____ Chickenpox	_____
_____ Measles	_____
_____ Mumps	_____
_____ Polio	_____
_____ Other: _____	_____

Gynecological History (women only)

Last menstrual period _____

How many pregnancies have you had? _____

How many children do you have? _____

Have you ever had an abnormal pap? _____

Have you had a hysterectomy? _____

Have your ovaries been removed? _____

Health Maintenance

When, if ever, did you last have any of the following:

_____ Cholesterol check	_____ Pap Smear
_____ Colonoscopy	_____ Prostate exam
_____ EKG/Cardiogram	_____ Cardiac stress test
_____ Mammogram	_____ Bone Density

List Year of Last Vaccinations:

_____ Tetanus (TD)	_____ Hepatitis A
_____ TB Skin Test	_____ Hepatitis B
_____ Pneumonia	_____ Shingles (Zostavax)

Health Maintenance continued

Name: _____
Birthdate: _____

Family History

Has any blood relative ever had any of the following :

Relative (mother, father, sister, children)

Alcoholism _____
Asthma _____
Bleeding problems _____
Cancer _____
Type: _____
Diabetes _____
Emphysema _____
Glaucoma _____
Heart Attack _____
Heart Disease _____
High Blood Pressure _____
Mental Illness / Suicide _____
Osteoporosis _____
Seizures _____
Stroke _____
Thyroid _____

	Living	Deceased
	Age	Age (at death) & cause
Father	_____	_____
Mother	_____	_____
Brother	_____	_____
Sister	_____	_____
Son	_____	_____
Daughter	_____	_____
Husband/Wife	_____	_____

Social History

Marital Status? *Single* *Married* *Divorced* *Widow* *Partner*

Do you have children / dependents at home? **Yes / No** *How many?* _____

Are you employed? **Yes / No** *Occupation?* _____

Do you or have you ever smoked or chewed tobacco? **Yes / No** *When?* _____ *Quit date?* _____
Packs/cans/bags per day _____ / *yrs* _____ *Type?* _____ *How often?* _____

Do you or have you ever used illegal drugs? **Yes / No** *Type?* _____ *How often?* _____

Do you drink alcohol? **Yes / No** *Type?* _____ *How often?* _____

Have you been exposed to toxic substances? **Yes / No**

Do you drink caffeine daily? **Yes / No** *Type?* _____ *How often?* _____

Do you exercise regularly? **Yes / No** *Type?* _____ *How often?* _____

Do you wear seat belts? **Yes / No**

Do you have a living will or advance directives? **Yes / No**

What is your highest level of education? _____

Review of Symptoms

Please check any of the following that you are experiencing:

General Fatigue Fever Hopelessness Hot Flashes Insomnia Night Sweats Poor Concentration
Recent Weight Loss / Gain Loss of Interest in Usual Activities

Skin Change in Pigmentation Eczema Hives Jaundice Rashes

ENT Change in Vision / Hearing Dizziness Enlarged Glands Glaucoma Headaches
Hearing Loss Neck Stiffness Nose Bleeds Chronic Sinus or Ear Problems

Respiratory Asthma Difficulty Breathing Frequent Colds / Coughing Shortness of Breath
Spitting up Blood

Cardiac Angina Chest Pain Difficulty Walking 2 Blocks Heart Murmur High Blood Pressure
Palpitations Swelling of Hands / Feet

Gastrointestinal Abdominal Pain / Cramping Blood or Dark Stool Change in Bowel Habits Frequent Diarrhea
Frequent Indigestion / Heartburn / Gas / Bloating Hepatitis Hemorrhoids Vomiting Blood

Genitourinary Difficulty Urinating Frequent Urination Loss of Bladder Control Unsatisfactory Sex Life

Musculoskeletal Joint Pain or Swelling Difficulty Walking Muscle Cramping or Weakness Varicose Veins

Neuropsychiatric Prior Treatment for Depression / Psychiatric Care Fainting Spells Paralysis Convulsions

Hematologic Easy Bruising Excessive Bleeding After Cuts Slow Healing After Cuts