

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**FAMILY HISTORY**

Relationship	Health/Problems	If Deceased, Cause and Age
<b>Father</b>		
<b>Mother</b>		
<b>Father's Parents</b>		
<b>Mother's Parents</b>		
<b>Brother/Sister</b>		

<b>IMMUNIZATIONS:</b> Tetanus/Date _____ Pneumonia/Date _____ Hepatitis A/Date _____ Hepatitis B/Date _____ Chicken Pox/Date _____ Flu Vaccine/Date _____	<b>CURRENT MEDICATIONS:</b> (Including Over-Counter Meds) _____ _____ _____	<b>MEDICATION ALLERGIES: List Drugs</b> _____ _____ _____
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**PERSONAL HABITS**

Do you currently smoke?  Yes  No      If Yes:  Cigarettes  Pipe  Cigars    Number a day \_\_\_\_\_  
Have you ever smoked?  Yes  No      Age Started \_\_\_\_\_      Age Stopped \_\_\_\_\_  
Reason for stopping \_\_\_\_\_  
Have you ever regularly chewed or dipped tobacco?  Yes  No      If Yes: How Long? \_\_\_\_\_ Amount per Day \_\_\_\_\_      Current  Stop  
Do you drink alcohol?  Yes  No      If yes, indicate frequency:  Rarely  Several times per month  Several times per week  Daily  
Has drinking ever caused you a problem?  Yes  No      If yes, drinking caused a problem with:  Job  Family  Friends  Police  
Have you ever used recreational drugs?  Yes  No      Does your home have Smoke Detector   
Do you currently use any drugs?  Yes  No      Do you have a regular: Dentist?  Eye Doctor?  Glasses?  Contacts?   
Are you sexually active?  Yes  No      Have you ever been sexually active?  Yes  No  
Your sexual orientation is:  Heterosexual (opposite sex)  Homosexual (same sex)  
Do you exercise regularly?  Yes  No      Do you have tattoos?  Yes  No  
Have you had a colonoscopy  Yes  No  Normal  Abnormal \_\_\_\_\_ Date \_\_\_\_\_  
Do you wear a safety belt when riding in a car?  Yes  No  Always  Usually  Sometimes  Never  
What is your religious preference? \_\_\_\_\_ How important is spirituality to your daily life?  Very  Somewhat  Not

**WOMEN ONLY-MENSTRUAL HISTORY**

Period Began \_\_\_\_\_      Are Periods Regular  Yes  No      Usual Duration (Days) \_\_\_\_\_  
Menstrual Flow is Usually:  Heavy  Moderate  Light    Severe Cramps  Yes  No      Pain/Bleeding during/after sex?  Yes  No  
Date of start of your last period \_\_\_\_\_    Age your periods stopped \_\_\_\_\_      Are you on Hormone Replacement?  Yes  No  
Date of your last pap smear \_\_\_\_\_       Normal  Abnormal      Date of last Mammogram \_\_\_\_\_       Normal  Abnormal  
Have you ever had a Bone Density Test  Yes  No  Normal  Abnormal      What is your form of birth control? Name \_\_\_\_\_

**PREGNANCY HISTORY**

# Of Pregnancies \_\_\_\_\_    # Born Alive \_\_\_\_\_    # Still Births \_\_\_\_\_    # Premature Births \_\_\_\_\_    # C-Sections \_\_\_\_\_  
# Of Miscarriages \_\_\_\_\_    # of Abortions \_\_\_\_\_    Complications with Pregnancies  Yes  No  
If yes, explain \_\_\_\_\_

Name (please print)			Date
Age	Birth Date	Race	Birthplace
__ Male __ Female		__ Married __ Single __ Widow(er) __ Separated/Divorced	
<b>PERSONAL PAST MEDICAL HISTORY (Check)</b>			
<input type="checkbox"/> Allergies	<input type="checkbox"/> Cancer	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Neurological Disorders
<input type="checkbox"/> Abnormal PAP Smear	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Gout	<input type="checkbox"/> Nervous Breakdown
<input type="checkbox"/> AIDS	<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Heart Problem	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cholesterol Problems	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Prostate Problem
<input type="checkbox"/> Angina Pectoria	<input type="checkbox"/> Colitis	<input type="checkbox"/> HIV Positive	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Genital Warts	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Sinus Problem
<input type="checkbox"/> Asthma	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Urinary Infections	<input type="checkbox"/> Stomach Ulcers
<input type="checkbox"/> Back Problem	<input type="checkbox"/> Depression	<input type="checkbox"/> Kidney Problem	<input type="checkbox"/> Stroke
<input type="checkbox"/> Bleeding Disorders	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Liver Problem	<input type="checkbox"/> Thyroid Problem
<input type="checkbox"/> Blindness	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Malformation	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> Epilepsy/Seizures	<input type="checkbox"/> Mental Illness	<input type="checkbox"/> Veneral Disease/STD
<input type="checkbox"/> Blood Transfusion	<input type="checkbox"/> Gallbladder Problem	<input type="checkbox"/> Migraine Headaches	Other _____

**LIST ANY SURGERIES & DATES:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CURRENT SYMPTOMS: (Please Check )**

<input type="checkbox"/> Fever	<input type="checkbox"/> Ringing in Ears	<input type="checkbox"/> Seeing Double	<input type="checkbox"/> Black Stools
<input type="checkbox"/> Poor Appetite	<input type="checkbox"/> Earache	<input type="checkbox"/> Memory Loss	<input type="checkbox"/> Urinating Frequently
<input type="checkbox"/> Recent Weight Loss	<input type="checkbox"/> Nose Bleeds	<input type="checkbox"/> Numbness or Tingling	<input type="checkbox"/> Burning or Pain When
<input type="checkbox"/> Recent Weight Gain	<input type="checkbox"/> Persistent Hoarseness	<input type="checkbox"/> Loss of Balance	<input type="checkbox"/> Urinating
<input type="checkbox"/> Unusual Thirst	<input type="checkbox"/> Cough	<input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Difficulty Urinating
<input type="checkbox"/> Difficulty Sleeping	<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Tremor	<input type="checkbox"/> Blood in Urine
<input type="checkbox"/> Feel Unusually Tired	<input type="checkbox"/> Sputum/Phlegm Present	<input type="checkbox"/> Personality Change	<input type="checkbox"/> Discharge From Penis
<input type="checkbox"/> Trouble Sleeping	<input type="checkbox"/> Trouble Breathing	<input type="checkbox"/> Feel Nervous	<input type="checkbox"/> Vaginal Bleeding
<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Wheezing	<input type="checkbox"/> Feel Depressed	<input type="checkbox"/> Vaginal Discharge
<input type="checkbox"/> Skin Rash	<input type="checkbox"/> Coughing Up Blood	<input type="checkbox"/> Feel Suicidal	<input type="checkbox"/> Vaginal Itching
<input type="checkbox"/> Itching	<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Nausea	<input type="checkbox"/> Abnormal Menstrual Period
<input type="checkbox"/> Changing Skin Mole	<input type="checkbox"/> Chest Tight/Pressure	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Breast Lump
<input type="checkbox"/> Unusual Skin Growth	<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Stomach Pain	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Unusual Hair Growth/Loss	<input type="checkbox"/> Sweating	<input type="checkbox"/> Trouble Swallowing	<input type="checkbox"/> Joint Pain/Stiffness
<input type="checkbox"/> Trouble Seeing	<input type="checkbox"/> Leg Pain	<input type="checkbox"/> Vomiting Blood	<input type="checkbox"/> Joint Swelling
<input type="checkbox"/> Pain in Eyes	<input type="checkbox"/> Freq/Severe Headaches	<input type="checkbox"/> Diarrhea	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Trouble Hearing	<input type="checkbox"/> Dizziness/Lightheadedness	<input type="checkbox"/> Constipation	<input type="checkbox"/> Muscle or Body Ache
<input type="checkbox"/> Wear Hearing Aid	<input type="checkbox"/> Blackout Spells	<input type="checkbox"/> Blood in Stools	