Patient Name: _____

Personal Medical History

Please circle all that apply:

Alcohol Abuse	Atrial Fibrillation / A-Fib	Cancer
Drug Abuse	Stroke	Bipolar Disorder
Anemia	Chronic Kidney Disease	Abnormal Pap Smears
Shingles	Hepatitis A	Gout
High Cholesterol	Hepatitis B	Abnormal Heart Beat
TB	Hepatitis C	Colon Polyps
Rash	Genital Herpes	Blood Disorder
Ulcers	Heart Disease	Diabetes Type 1
Anxiety	Glaucoma	Diabetes Type 2
Depression	Acid Reflux	Liver Disease
Arthritis	High Blood Pressure	COPD
Asthma	Seizures	Emphysema
Thyroid Disorder	Congestive Heart Failure	B12 Deficiency

Reproductive History

Are you Pre Menopausal? Yes No If yes, Date of last menstrual cycle: _____

Are you Post Menopausal? Yes No If yes, Age at Menopause: _____

Are you on Hormone Replacement Therapy? Yes No If Yes, Medication use: _____

Total # of pregnancies: _____ # of children: _____ # of miscarriages: _____ Ages: _____

Have you had a Hysterectomy? Yes No If yes, Total or Partial? _____

Immunization History

Please list dates for immunizations that you have received:

Influenza: _____

Shingles: _____

Tetanus: _____

Pneumonia: _____

Patient Name: _____

Preventive Procedures

Please list most recent dates for procedures that you have had

Mammogram: _____ Labs: _____

Bone Scan: _____ Physical: _____

Pap Smear: _____ Prostate Check: _____

EKG: _____ Other: _____

Colonoscopy: _____ Other: _____

Surgical History

Please list all surgeries you have had along with dates

_____

_____

_____

_____

_____

Non Surgical Hospitalizations

Please list all hospitalizations EXCEPT surgeries, along with dates

_____

_____

_____

_____

Other Providers

Please list all other providers that you see and their phone numbers

_____

_____

_____

Patient Name: _____

Drug Allergies

Do you have allergies to any medications? Yes No If Yes, Please list the medications and reaction.

_____

_____

Environmental Allergies

Do you have allergies to any environmental elements? Yes No If yes, Please list the elements and reaction.

_____

_____

Food Allergies

Do you have allergies to any food products? Yes No If yes, Please list the food products and reaction.

_____

_____

Social History

Please circle all that apply:

Tobacco: **Current** **Former** **Never**
If current, how many packs per day? _____
If former, how many packs per day _____ years smoked_____ quit date _____

Alcohol: **Current** **Former** **Never**
If current, how many drinks and how often? _____
If former, how many drinks per day _____ years drank _____ quit date _____

Diet: Are you on a special diet? **Yes** **No**
If yes, please explain. _____

Exercise: Do you exercise? **Yes** **No**
If yes, how often? _____

Illicit Drugs: **Current** **Former** **Never**
If current, drug of choice and how often? _____
If former, drug of choice and how long ago did you quit? _____

Hobbies: Please list hobbies that you have: _____

_____

_____