Patient Name: _____

Please List and Supply the Dates of:

Operations: _____ _____ _____

_____ _____ _____

Hospitalizations Other than for Surgery: _____ _____

_____ _____ _____

Immunization History – Have You Had: Pneumovax Immunization □No□Yes When? _____

Hepatitis B? □No □ Yes When? ____ Flu Immunization? □ No□ Yes When? _____

Other? □No □ Yes When? ____ Tetanus Immunization? □No □ Yes When? _____

When Was Your Last:

Pap Smear? _____Breast Exam? _____Stool Check for Blood? _____

Mammogram? _____Cholesterol Check? _____Prostate Exam? _____

Family History

Has Any Member of Your Family (Including Parents. Grandparents, and Siblings) Ever Had the Following?

Illness When Diagnosed	Which Family Members?	Approx. Age
Cancer (Describe Type)		
Hypertension (High Blood Pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental Disease (Anxiety, Depression, Etc.)		
Drug or Alcohol Addiction		
Glaucoma		
Bleeding Diseases		
Other:		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose

Prevention

Do You Wear Seat Belts? □Yes □No If Not, Why Not? _____

Do You Wear a Bike Helmet? □Yes □No □ N/A

Do You Smoke? □Yes □ No If Yes, How Many Packs Per Day? _____

Do You Drink Alcoholic Beverages? □Yes □No If Yes, How Much Per Week? _____

Do You Drink Coffee? □ Yes □No If Yes, How Many Cups Per Day? _____

Do You Drink Tea? □Yes □No If Yes, How Many Cups Per Day? _____

If There Is a Gun in Your Home, Do You Keep it Unloaded and Out of Children's Reach? □Yes □ No N/A

Do You Use Drugs? (Marijuana, Cocaine, etc.) □Yes □No If Yes, Explain: _____

Have You Ever Engaged in any Activity which Has Put You at Risk of Getting AIDS? □Yes □No If Yes, Explain: _____

Do You Wish to be Tested for AIDS? □Yes □ No

Have You Ever Worked with Chemicals, Paints, Asbestos, Or Other Hazardous Material? □Yes □ No If Yes, Explain: _____

Are You in a Relationship in Which You Have Been Physically Hurt (e.g. Slapped, Kicked, Punched, Bruised) By Your Partner? □Yes □ No

Do You Ever Feel Afraid of Your Partner? □Yes □No □N/A

Do You Have A "Living Will"? □Yes □No

Do You Have a Donor Card? □Yes □No

Method of Birth Control? _____

This information is for use by your physician as part of your confidential medical record.

Patient Name: _____ **Age:** _____

Address: _____ **Sex:** □ **M** □ **F**

_____ **Home Phone:** _____

_____ **Work Phone:** _____

Occupation: _____ **Emerg. Contact:** _____

Phone: _____

☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed** ☐**Divorced**

If Married, Spouse's Name: _____

Children's Names and Ages: _____

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

(If Yes, Please List Names of Medicine and Type of Reaction):

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

Past Medical History and Review of Systems

Please Circle If You have Had Problems With, or Are Presently Complaining of Any of the Following:

1. High Blood Pressure	13. Bronchitis	26. Change in Bowel Habits	38. Arthritis
2. Diabetes	14. Pneumonia	27. Unexplained Weight Gain/Loss	39. Low Back Problems
3. Cancer	15 Persistent Cough	28. Hemorrhoids	40. Skin Diseases
4. Heart Disease	16. T.B.	29. Gall Bladder Disease	41. Blood Disorders
5. Chest Pain/Tightness	17. Hay Fever	30. Colitis	42. Venereal Diseases
6. Shortness of Breath	18. Abdominal Discomfort	31. Hepatitis or Jaundice	43. Anxiety
7. Swollen Ankles	19. Indigestion	32. Thyroid Disease	44. Depression
8. Palpitations	20. Nausea	33. Head or Neck Radiation	45. Anemia
9. Lightheadedness	21. Vomiting	34. Constipation	46. Alcohol Abuse
10.Frequent Urination	22. Constipation	35. Kidney Diseases	47. Drug Abuse
11. Rheumatic Fever	23. Diarrhea	36. Kidney Stones	48. Gout
12. Asthma	24. Blood in Stool	37. Difficulty Urinating	49. Achieve Erection
	25. Ulcers		50. Maintain Erection

_____

_____

_____

Gynecologic and Obstetric History

Age at Onset of Periods: _____ Frequency: _____ Length of Period: _____

Pregnancies: _____ Births: _____ Miscarriages: _____

Prolonged or Abnormal Bleeding: ☐ No ☐ Yes (Please Describe): _____

Leakage of Urine: ☐ No ☐ Yes (Please Describe): _____

Pelvic Pain: ☐ No ☐ Yes (Please Describe): _____

Abnormal Discharge: ☐ No ☐ Yes (Please Describe): _____

History of Abnormal Pap Smear: ☐ No ☐ Yes (Type of Treatment): _____

This Information is for use by your physician as part of your confidential medical record.

Please continue on next page.