TODAY'S DATE_____

MEDICAL HISTORY

NAME | AGE | BIRTHDATE

ADDRESS | SEX M ☐ F ☐

HOME PHONE

WORK PHONE

OCCUPATION | EMERGENCY CONTACT

RELATIONSHIP

PHONE

SPOUSE, PARTNER, SIGNIFICANT OTHER'S NAME:

CHILDREN'S NAME AND AGES:

Allergies to medications, X-Ray Dyes, or other substances ☐ **NO** ☐ **YES**
(if yes, please list name of medicine/substance and reaction):

MEDICAL HISTORY

Please circle if you have had problems with or are presently experiencing any of the following:

High Blood Pressure		
Diabetes	Constipation	Skin Disease
Cancer		Headache
type	Blood in Stool	Menstruation Disorder
	Ulcer	Anemia
Heart Disease	Weight Loss	Venereal Disease
Heart Attack		Anxiety
High Cholesterol	Gall Bladder Disease	Depression
	Colitis	
osteoporsis	Hepatitis or Jaundice	Alcohol Difficulty
Rheumatic Fever	Thyroid disease	Drug Use
	Head or Neck Radiation	
Asthma		Pregnancy
Emphysema	Kidney Disease	
Chronic Bronchitis	Kidney Stones	**OTHER:**
"COPD"	Prostate Disease	
Pneumonia		
Tuberculosis	Arthritis	
	Low Back Problems	
	Gout	

Please list hospitalizations (including surgery) and their dates:

t

TURN OVER FOR 2nd PAGE

List immunizations you have had:

Date	Date	Date	Date
Hepatitis A	Flu	Tetanus	Other
Hepatitis B	Pneumovax	Measles/Mumps/Rubella	

When was your last:

Date	Date	Date
PAP Smear	Breast Exam	Cholesterol Check
Mammogram	Prostate Exam	Colonoscopy
Bone Density		

FAMILY HISTORY

Has any member of your family(parents, grandparents,brothers,sisters,etc)had the following?

Please note the age when diagnosed!

	Which family member(s)?	**AGE Diagnosed**
Cancer(breast,colon,prostate,skin)		
Hypertension (high blood pressure)		
Heart disease/heart attack		
Stroke		
Diabetes		
High Cholesterol		
Mental disease (depression, anxiety, etc)		
Drug or Alcohol Addiction		
Glaucoma		
Thyroid disease		
Other		

MEDICATION (Prescription, Over-the-Counter, Vitamins, Herbs, Homeopathic)

name	*dose*	*name*	*dose*	*name*	*dose*

PREVENTION	NO	YES	
Do you exercise? How often?			
Do you have a living will? Health care proxy?			
Do you have a donor card?			
Do you smoke?			How much /week?
Do you drink alcoholic beverages?			How much /week?
Do you drink coffee?			How much/day?
Do you drink tea?			How much day?
Do you use drugs? (marijuana, cocaine, etc)			Explain:
Do you wear seat belts?			
Have you ever been threatened, or physically hurt (slapped, kicked, punched, etc) by your partner?			
Do you ever feel afraid of your partner?			
If there is a gun in your home, is it out of childrens' reach and unloaded?			
Have you ever engaged in any activity which has put you at risk for AIDS?			Explain:
Do you wish to be tested for AIDS?			
Method of birth control? Not applicable?			
Have you ever worked with hazardous materials?			Explain: