

PLEASE FILL OUT & RETURN TO FRONT DESK.

Name: _____ DOB: _____

Medical History: Please check those conditions that NOW or HAVE EVER applied to you:

- | | | | | | |
|--|-------------------------------------|--|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Dementia | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Enlarged Prostate | <input type="checkbox"/> Migraine | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Dermatitis | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Gout | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Headache | <input type="checkbox"/> Coronary Artery Disease |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> HIV | <input type="checkbox"/> Back Problems | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Congestive Heart Failure |
| <input type="checkbox"/> COPD | <input type="checkbox"/> GERD | <input type="checkbox"/> Renal Stone | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other Cancer What type? _____ | | | | | |

Other conditions not listed above? _____

Medication List: Please list any medications you are currently taking:

Have you recently had any immunizations or injections? (ex. flu shot, pneumonia, tetanus, hepatitis, etc.) Yes No If yes, please list: _____

Allergies: Yes No If yes, please list: _____

Surgical History: Please fill out past surgical history: _____

Obstetric History: Are you currently pregnant? Yes No If yes, how many weeks? _____

Total Preg	Full Term	Premature	Ab Induced	Ab Spontaneous	Ectopics	Multiple Births	Living

Social History:

Do you smoke? Yes No If yes, how often, how much? _____

Do you drink? Yes No If yes, check all that apply: beer wine hard alcohol

How often & how much? _____

Do you currently take or have you taken any illegal drugs or abused prescription drugs? (ex. cocaine, heroin, oxycodone, amphetamines, etc.)

Yes No If yes, how often & how much? _____

Family History: Check any **RELEVANT** conditions associated with family members and fill in the relationship.)Check "M" for Maternal and "P" for Paternal when specifying Mother or Father's side of the family).

	✓Yes	✓No	Relationship		✓Yes	✓No	Relationship
<input type="checkbox"/> Asthma			<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Enlarged Prostate			<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Anemia			<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Heart Attack			<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Arthritis			<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Hepatitis			<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Anxiety			<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Back Problems			<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> COPD			<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Glaucoma			<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Dementia			<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Migraine			<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Dermatitis			<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Gout			<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Diabetes			<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Headache			<input type="checkbox"/> M <input type="checkbox"/> P

<i>See other side....</i>							
	✓Yes	✓No	Relationship		✓Yes	✓No	Relationship
<input type="checkbox"/> Epilepsy			<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Thyroid Disease			<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> GERD			<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Ulcer			<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Stroke			<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> High Cholesterol			<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Breast Cancer			<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> High Blood Pressure			<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Depression			<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Coronary Artery Disease			<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Pneumonia			<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Congestive Heart Failure			<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> HIV			<input type="checkbox"/> M <input type="checkbox"/> P	<input type="checkbox"/> Tuberculosis (TB)			<input type="checkbox"/> M <input type="checkbox"/> P
<input type="checkbox"/> Renal Stone			<input type="checkbox"/> M <input type="checkbox"/> P				<input type="checkbox"/> M <input type="checkbox"/> P
			<input type="checkbox"/> M <input type="checkbox"/> P				<input type="checkbox"/> M <input type="checkbox"/> P
			<input type="checkbox"/> M <input type="checkbox"/> P				<input type="checkbox"/> M <input type="checkbox"/> P

Fill out those who are **DECEASED**. If known, fill in the **age at death** and the **cause of death**.

Family Member	Death Age	Cause of Death	Family Member (Brothers & Sisters)	Death Age	Cause of Death
Father			<input type="checkbox"/> M <input type="checkbox"/> F		
Mother			<input type="checkbox"/> M <input type="checkbox"/> F		
Maternal Grandmother			<input type="checkbox"/> M <input type="checkbox"/> F		
Maternal Grandfather			<input type="checkbox"/> M <input type="checkbox"/> F		
Paternal Grandmother			<input type="checkbox"/> M <input type="checkbox"/> F		
Paternal Grandfather			<input type="checkbox"/> M <input type="checkbox"/> F		

Adopted History Unknown

Other comments: _____
