

Name: _____

Date of Birth: ___/___/___ Male Female Today's Date: _____

What is the reason for today's visit? _____

No Known Allergies

Allergies: Latex Food _____ Medications: _____

MEDICATIONS: list all medications you take, (including over the counter, herbal, natural remedies)

HEALTH HISTORY: have you ever had or been diagnosed with having (check all that apply)

Anemia	Cataracts	Glaucoma	Kidney Disease	Rheumatic Fever
Angina	Chicken Pox	Heart Attack	Kidney Stones	Seizure/Epilepsy
Arthritis	Dementia	Heart Disease	Lung Disease	Sleep Apnea
Asthma	Depression / Anxiety	Heart Murmur	Measles	Stomach Ulcers
Bleeding Disorder	Diabetes	Hemorrhoids	Migraines/ Headaches	Stroke
Blood Clots (DVT/PE)	Digestive Disorders	High Blood Pressure	Pneumonia	Thyroid Disease
Blood Transfusion	Frequent Infections	High Cholesterol	Pre-Diabetes	Tuberculosis
Cancer	type of cancer:	Jaundice or Liver Disease	Prostate Enlargement	Other:

Have you had Surgery, or been Hospitalized? Have you been to the Emergency Room in the past year?

Type of Surgery/Reason for Hospitalization/ Reason for Emergency Room visit	Date

IMMUNIZATIONS (check if yes and indicate year of last injection)

Vaccine	Year	Vaccine	Year
Influenza		Zoster (Shingles)	
Tetanus		Hepatitis B	
Pneumonia		MMR (Measles, Mumps & Rubella)	
Varicella (Chicken Pox)		Other:	
Tdap (Tetanus, Diphtheria & Pertussis)			

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HEALTH HABITS: check which apply (if current please indicate amount)

	Never	Past	Current	Amount
Tobacco Use				
Alcohol Use				
Seat Belt Use				
Exercise				

HEALTH MAINTENANCE: Have you had any of the following? (if YES indicate when)

	NO	YES	DATE
Mammography (Females age 40-69)			
Pap Smear (Females age 18-75)			
Colonoscopy (age 50-75)			
Bone Density (age >65)			
Last Menstrual Period (females)			
Gynecologist (females)	NAME		

FAMILY HISTORY

Relation	√ If Alive	Age at Death	Medical conditions/ Cause of Death
Mother			
Father			
Brothers			
Sisters			
Children			
Grandparents			

DO ANY OF YOUR BLOOD RELATIVES HAVE ANY OF THE FOLLOWING?

Disease	Relationship to You
Anemia	
Arthritis	
Asthma	
Blood Clots	
Cancer	
Diabetes	
Heart Disease	
High Blood Pressure	
Kidney Disease	
Stroke	
Other:	