Patient Name:_____ Birthdate:_____ Patient#:_____

Past Medical History

Have you ever had the following: (Circle "no" or "yes", leave blank if uncertain)

Diabetes……..	no	yes	Heart Disease…….	no	yes	Kidney Disease……..	no	yes
Asthma……	no	yes	Lung Disease……	no	yes	HIV……..	no	yes
Blood Disorder……	no	yes	Bleeding Tendency……..	no	yes	Tuberculosis……	no	yes
Hepatitis…….	no	yes	Chickenpox……	no	yes	Venereal Disease……	no	yes
Measles……	no	yes	Arthritis……..	no	yes	Anemia……	no	yes
Epilepsy……..	no	yes	Cancer…….	no	yes	Glaucoma……	no	yes
High Blood Pressure…..	no	yes	Blood Transfusion……..	no	yes	Stroke…….	no	yes
Thyroid Disease…….	no	yes	Ulcer……	no	yes	Any other_____		

Preventive Maintenance: (list the most recent time you have had any of the following)

Physical Exam	Never:_____	Date:_____
Cholesterol Check	Never:_____	Date:_____
Tetanus Shot	Never:_____	Date:_____
Colonoscopy	Never:_____	Date:_____

Previous Hospitalizations/Surgeries/Serious Illnesses	When?	Hospital,City,State
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications: (include nonprescription) _____

_____

_____

Allergies: (include medicines and other substances) _____

_____

_____

Family Medical History:

	Age	Diseases	If Deceased, Age, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____
	_____	_____	_____

Patient Social History:

Marital Status	Single:_____	Married:_____	Separated:_____	Divorced:_____	Widowed:_____
Use of Alcohol:	Never:_____	Type/Freguency:_____			
Use of Tobacco	Never:_____	Previously, but quit:_____	Packs/Day:_____		
Use of Drugs:	Never:_____	Type/Frequency:_____	IV Drugs:…….no	yes	

Review of Symptoms: (Please indicate any <u>current</u> areas of concern)

Fever/Infection…….	no	yes	Eyes…….	no	yes	Ears/Nose/Mouth/Throat……..	no	yes
Heart/Circulation……	no	yes	Lungs……	no	yes	Abdomen/Stomach/Bowels……..	no	yes
Kidney/Bladder……..	no	yes	Gynecological…	no	yes	Sexual Difficulty……..	no	yes
Musculoskeletal/Joint….	no	yes	Skin/Rash…….	no	yes	Neurological/Headaches……	no	yes
Psychiatric/Depression…	no	yes	Allergies……	no	yes	Endocrine/Thyroid/Diabetes…….	no	yes

Women (Additional History)

Last Menstrual Period	Date:_____	Are Periods Still Regular?…….	no	yes	Hysterectomy?……	no	yes
Last Pap Smear	Date:_____	Abnormal Paps?……	no	yes	Hormones/Birth Control...	no	yes
Number of Pregnancies	_____	Number of Miscarriages	_____				
Last Mammogram	Date:_____	Last Bone Density Scan:	Date:_____				