Name:_____ Date of Birth:_____ Date:_____

Please list any medical problems/diseases you have:

_____ _____

_____ _____

_____ _____

Please list all medications, herbals and vitamins you are taking:

Name	Dose/Strength	How often do you take

Please list all Drug allergies:

Allergic to:	Reaction

FAMILY HISTORY

Please list all family members including mother, father, sisters, and brothers.

☐ Check here if adopted

Family Member	Name	Medical Problems/Diagnosis	Age	Deceased
Mother				
Father				
Mat Grand Mother				
Mat Grand Father				
Pat Grand Mother				
Pat Grand Father				
Mat Aunt				
Mat Uncle				
Mat Aunt				
Pat Aunt				
Pat Uncle				

Name:_____ Date of Birth:_____ Date:_____

SURGICAL HISTORY

Please list all surgeries or procedures you have had.

Date	Type of Surgical Procedure or Hospitalization	Reason for surgery or Hospitalization	Hospital	Name of Surgeon

List all other specialist you are currently seeing:

_____

_____

_____

Social History

Date of Birth:_____

Level of education completed: _____

What do you do for work: _____

Children:

☐ Yes ☐ No

Tobacco:

Are you a smoker: ☐Yes ☐No Former ☐

Pack(s)/day :_____

Years smoked: _____ Year Quit: _____

Alcohol:

Do you drink alcohol: ☐ Yes ☐ No ☐ Formerly ☐ Year Quit:

Type: ☐ Beer ☐ Hard Liquor ☐ Wine

Recent Travel

Any recent travel out of the state? ☐ Yes ☐ No

Any recent travel out of the country? ☐ Yes ☐ No

Advanced Directives in Place

Mark the advanced directives that you currently have in place:

None ☐ DNR ☐ Living Will ☐ Durable Power of Attorney ☐ HC Prox

Do you agree to a transfusion? ☐ Yes ☐ No

Name:_____ Date of Birth:_____ Date:_____

HEALTH MAINTENANCE

Please fill in the date of your most recent health maintenance event (if applicable):

Event	Date of Last
Colonoscopy/ GI procedure	
Stress test/ Cardiac procedure	
Echocardiogram	
Eye exam	
Skin exam	
Mammogram/ Breast exam	
Pap-smear	
PSA/ Prostate exam	
Rectal exam/ Stool cards/ FOBT	
Bone Density	
Foot Exam/ Monofilament	

Vaccine/Immunization	Date of Last
Tetanus (Td)	
Pneumonia vaccine	
Flu vaccine	
Hepatitis A vaccine	
Hepatitis B vaccine	
TB/ PPD (Tuberculosis screening)	
MMR (Measles, Mumps & Rubella)	
Zostavax	

Any concern for possible HIV infection? If so, please explain:

_____

_____

_____

_____

_____