DATE: _____

NAME: _____ AGE:_____ DATE OF BIRTH:_____

I. PAST MEDICAL HISTORY

A. Surgeries:

Tonsillectomy Date: _____ HysterectomyDate:_____AppendectomyDate:_____
Cholecystectomy Date: _____Other surgeries and dates:_____
Biopsies done: what kind and dates: _____

B. Medical Problems:

_____
_____
_____
_____

D. Present Medications (prescription and over-the-counter):

Name Dose #Taken daily Reason

_____
_____
_____
_____
_____

Herbs and Supplements: _____
_____

E. Allergies: _____ or ○ No known drug allergies
Medications: What reaction:

_____
_____

Other Substances, Foods, etc:

_____

F. Immunizations: Check Childhood Shots Given:

DPT _____ Mumps _____ Measles _____ Rubella _____ Polio ____ Smallpox _____
Tetanus Booster Date: _____
Pneumovax (pneumonia vaccine) Date: _____
Influenza (date of last shot) Date: _____
Hepatitis B (series of 3 shots) Date: _____
Others: Date: _____

II. FAMILY HISTORY

Mother: Age (if living) _____ Age (at death) _____ Cause of death _____
List any medical problems she has had:

_____

Father: Age (if living) _____ Age (at death) _____ Cause of death _____
List any medical problems he has had:

_____

Brother (s) Ages and any medical problems he/they have had:_____
_____

Sister (s) Ages and any medical problems she/they have had: _____

_____

Any other blood relatives with:

	Relationship		Relationship
Diabetes	_____	High blood pressure	_____
Heart attack	_____	Breast cancer	_____
Stroke	_____	Colon cancer	_____
Tuberculosis	_____	High cholesterol	_____
Alzheimer's	_____	Melanoma (skin cancer)	_____
Prostate cancer	_____	Ovarian cancer	_____

III. LIFESTYLE HISTORY

A. Marital Status:

Single ❑ Married ❑ Divorced ❑

Significant Other (male) ❑ Significant other (female) ❑

B. Have you ever been pregnant? Yes ❑ No ❑ N/A ❑

If yes, how many pregnancies? How many births / children?

C. smoker (currently) ❑ ex-smoker ❑ nonsmoker ❑ chewing tobacco ❑

If a smoker, number of packs (pipes, cigars) per day_____

How long have you smoked?_____ lf ex-smoker, when did you quit? _____

D. Alcohol intake:

What do you usually drink? _____ how much?_____ how often? _____

❑ Do not drink alcohol

E. Exercise:

Do you exercise regularly? _____ What activity_____

How often?_____ How long is each session? _____

F. Diet -Check any foods you **avoid** in your diet:

❑ salt ❑ sugar ❑ fats (oils) ❑ red meat ❑ eggs ❑ poultry ❑ wheat ❑ caffeine ❑ other

G. Usual number of meals per day: _____ Number of times per week you eat "fast foods" _____

H. Travel ; Have you recently traveled outside the U.S.? _____

Where did you go? _____

I. Work

Current Occupation: _____

Have you had any work related illnesses or injuries? _____

IV. REVIEW OF SYSTEMS

A. Presently or in the recent past, have you had any of the following symptoms:

( ) Recurrent headaches		( ) Weight loss # of pounds	
( ) Fever (unexplained)		( ) Chills	
( ) Generalized fatigue		( ) Generalized weakness	
( )Double vision		( ) Ringing in ears	
( ) Recurrent sinus infection		( ) Recurrent sore throats	
( ) Hoarseness		( ) Neck stiffness	
( ) Coughing up blood		( ) Chronic cough	
( ) Chest pressure or tightness on exertion		( ) Chest pressure of tightness at rest	
( ) Feeling dizzy or off-balance		( ) Pain in legs while walking	
( ) Change in appetite		( ) Abdominal burning pain	
( ) Nausea		( ) Diarrhea	
( ) Change in bowel habits		( ) Rectal bleeding	
( ) Painful urination		( ) Change in urinary habits	
( ) Breast Pain		( ) Weight gain # of pounds gained	
( ) Night Sweats		( ) Generalized body aches	
( ) Change in vision		( ) Change in hearing	
( ) Frequent nosebleeds		( ) Recurrent gum or tooth infections	
( ) Constant sinus drainage		( ) Trouble swallowing	
( ) Swollen glands		( ) Shortness of breath on exertion	
( ) Shortness of breath while laying down		( ) Coughing up phlegm in the morning	
( ) Feeling faint or almost passing out		( ) Swollen ankles or feet	
( ) Heartburn or indigestion		( ) Abdominal cramping pain	
( ) Vomiting		( ) Constipation	
( ) Blood in or on stool		( ) Frequent or urgent urination	
( ) Blood in urine		( ) Vaginal discharge or odor	
( ) Change in menstrual periods		( ) Change in sexual desire	
( ) Breast lump		( ) Nipple discharge	
( ) Testicular pain		( ) Skin rash	
( ) Easy bruising or bleeding		( ) Changes in hair	
( ) Trouble sleeping		( ) Depression	
( ) Muscle weakness or pain		( ) Tingling in hands or feet	
( ) Joint swelling		( ) Testicular swelling	
( ) Changes in skin or moles		( ) Lumps in neck, underarms or groin	
( ) Sensation of being too hot or too cold		( ) Nervousness, panic	
( ) Mood swings		( ) Numbness	
( ) Joint pains		( ) Seizures or convulsions	
( ) Head injury and loss of consciousness		( ) Memory loss	

List any other problems not mentioned above:

_____

_____

_____

V. HEALTH MAINTENANCE

A. Date of last physical / annual exam_____

B. Date of last Pap smear _____

C. Date of last Cholesterol level _____

D. Date of last EKG _____

E. Date of last Chest X-ray _____

F. Date of last Prostate exam _____

G. Date of last Complete blood tests _____

H. Date of last Thyroid level _____

I. Date of last Sigmoidoscopy or Colonoscopy _____

J. Date of last Bone density test _____

K. Date of last mammogram _____

L. Do you use a seat belt in your car? _____