DATE: ____________________ DOB: _____________

NAME: ____

WHAT BRINGS YOU IN TO THE CLINIC TODAY?

____

MEDICAL PROBLEMS	PERSONAL HISTORY
List any chronic or recurrent medical problems	Pharmacy: ______________________ 30 day 90 day
	Children: ________ ____ Sons ______Daughters

ALLERGIES	
List any allergies to medicines or other substances.	**Last Eye Exam:**
____	**Last Pap Smear:**
____	**Last Mammogram:**
	Last Colonoscopy:

SAFETY	SURGERY/HOSPITALIZATION
Do you use seatbelts regularly? ____Yes _____No	Date: ___________ Reason:_____________________
Do you use illicit drugs? _____Yes _____No	Date: ___________ Reason:_____________________
Do you use contraception? ____Yes ____ No	Date: ___________ Reason:_____________________
Do you have a living will? _____Yes _____No	Date: ___________ Reason:_____________________
	Date: ___________ Reason:_____________________

FAMILY HISTORY

Use the following diseases to fill in the table below

Alcoholism Aneurysm Arthritis Cancer (Type)____________ Breast Cancer Colon Cancer
Diabetes Heart Disease High Blood Pressure Heart Disease High Cholesterol Mental Illness
Seizures Thyroid Disorder Tuberculosis

Family Member	Health Problems	Age of Onset	Cause of Death if Deceased
Mother			
Father			
Sister			
Brother			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

SOCIAL HISTORY

TOBACCO USE:

Do You Smoke? ___ Yes ___ No ____Previous If Yes, how many packs per day? ____ How Long?_______

ALCOHOL USE: Do you drink Alcohol? ______ Yes ___ No If yes, how often per week? ________

DIET, EXERCISE & HABITS Do you use exercise regularly? ____Yes _____No

Nutrition: Circle Moderate Sugar Sodium Saturated Fat Cholesterol Intake Snacks