Your name _____ **Age** ____
Sex _____ **Marital status** _____
Date of birth _____
Occupation _____**Check if retired** ☐
Last grade finished _____
Hobbies/Interests _____
REASON FOR TODAY'S VISIT (_____)

Date

_____

_____

FAMILY HEALTH

	POOR ↓ GOOD		DIED	AGE & CAUSE OF DEATH
Grandfathers (natural)	☐	☐	☐	_____
Grandmothers (natural)	☐	☐	☐	_____
Father (natural)	☐	☐	☐	_____
Mother (natural)	☐	☐	☐	_____
Brothers/Sisters (natural)				
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
Spouse/Partner _____	☐	☐	☐	_____
Children (natural)				
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____
_____	☐	☐	☐	_____

IMMUNIZATIONS/VACCINES **Note yr. last received.**

☐ **Pneumonia** _____ ☐ **Measles** _____ ☐ **Mumps** _____
☐ **Influenza** _____ ☐ **Tetanus** _____ ☐ **Rubella** _____
☐ **Polio** _____ ☐ **Hepatitis B** _____
☐ **Hepatitis A** _____

WOMEN'S GYNECOLOGIC HISTORY

Age when menses first began_____
Date of last menstrual period _____
Number of pregnancies _____
Number of live births _____

MEDICATION/FOOD/PRODUCT ALLERGIES

List and explain nature of reaction.

_____
_____
_____
_____
_____

ILLNESSES **Check the ☐ (box) if *you've* ever had any of the following. Check the O (circle) if a close *blood relative* has ever had any of these.**

☐ O **Alcoholism**	☐ O**Suicide attempt**
☐ O **Anemia**	☐ O **Eye problems**
☐ O **Arthritis**	☐ O **Blood clot**
☐ O **Bleeding easily**	☐ O **Thyroid disease**
☐ **Blood transfusion**	☐ **Venereal disease**
☐ O **Diabetes**	☐ O **Cancer**
☐ O **Drug abuse**	☐ O**High blood pres.**
☐ O **Depression**	☐ **Stomach ulcer**
☐ O **Skin problems**	☐ O **Stroke**
☐ O **Liver disease**	☐ O **Kidney disease**
☐ O **Lung disease**	☐ **Measles, mumps**
☐ O **Seizures/epilepsy**	☐ **Rubella**
☐ O **Heart disease**	☐ **Chicken pox**
☐ **Rheumatic fever**	☐ O **Osteoporosis**
☐ **Environmental allergies**	☐ **HIV/AIDS**
☐ **Other**_____	☐ O **Mental illness**
_____	
☐ **Other**_____	☐ **Other**_____
_____	_____

HOSPITALIZATIONS/SURGERIES

List illnesses and operations with year.

_____
_____
_____
_____
_____
_____

MEDICATIONS/SUPPELMENTS YOU ARE USING **List those by prescription and those over-the-counter, dose, and how used.**

_____
_____
_____
_____
_____
_____