Your answers on this form will help your clinician understand your medical concerns and conditions. If you are uncomfortable with any question, do not answer it. Best estimates are fine if you cannot remember specific details or date. Thank you!

# PERSONAL INFORMATION:

Full Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:

Date:

Current Health Concerns:

**MEDICATIONS:** (Prescription and non-prescription medications, vitamins, birth control pills, herbs and supplements.)

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| **MEDICATION** | **DOSE** | **FREQUENCY** | **MEDICATION** | **DOSE** | **FREQUENCY** |
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**Drug Allergies or Reactions to Medications / Foods / Other Agents:** □ Yes □ No Please list:

**PERSONAL MEDICAL HISTORY:** Do you have any of the following?

□ Acid Reflux (heartburn) □ Alcoholism □ Allergies (environmental)

□ Anxiety □ Asthma □ Atrial Fibrillation

□ Cancer (list below) □ Cholesterol Problem □ Coagulation (bleeding) Problem

□ Chronic Low Back Pain □ Depression □ Diabetes

□ Erectile Dysfunction □ Gout □ High Blood Pressure

□ Heart Disease (explain below) □ Migraines □ Osteopenia / Osteoporosis

□ Prostate Problems □ Thyroid Problems

□ Other Chronic or Recurring Medical Problems (Please list below)

**PRIOR SURGERIES AND HOSPITALIZATIONS:** □ Yes □ No (Please list all prior operations and hospitalizations)

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| **DATE** | **SURGERY OR HOSPITALIZATION** | **DATE** | **SURGERY OR HOSPITALIZATION** |
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Have you received a blood transfusion? □ Yes □ No When?

**FAMILY HISTORY:** Please indicate with a check any family members who have had any of the following conditions: Check here if you don’t know your family history □

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| **MEDICAL CONDITION** | **M O M** | **D A D** | **B R O** | **S I S** | **D A U G** | **S O N** | **OTHER CLOSE RELATIVES** | **MEDICAL CONDITION** | **M O M** | **D A D** | **B R O** | **S I S** | **D A U G** | **S O N** | **OTHER CLOSE RELATIVES** |
| Alcoholism |  |  |  |  |  |  |  | Genetic Diseases |  |  |  |  |  |  |  |
| Anemia |  |  |  |  |  |  |  | Glaucoma |  |  |  |  |  |  |  |
| Anesthesia Problem |  |  |  |  |  |  |  | Allergies |  |  |  |  |  |  |  |
| Arthritis |  |  |  |  |  |  |  | High Cholesterol |  |  |  |  |  |  |  |
| Asthma |  |  |  |  |  |  |  | Heart Disease (Heart attack, stent or bypass surgery) |  |  |  |  |  |  |  |
| Birth Defects |  |  |  |  |  |  |  | High Blood Pressure |  |  |  |  |  |  |  |
| Cancer, Breast |  |  |  |  |  |  |  | Kidney Disease |  |  |  |  |  |  |  |
| Cancer, Colon |  |  |  |  |  |  |  | Migraine Headaches |  |  |  |  |  |  |  |
| Cancer, Melanoma |  |  |  |  |  |  |  | Osteoporosis |  |  |  |  |  |  |  |
| Cancer, Other Skin |  |  |  |  |  |  |  | Rheumatoid Arthritis |  |  |  |  |  |  |  |
| Cancer, Ovary |  |  |  |  |  |  |  | Seizures |  |  |  |  |  |  |  |
| Cancer, Prostate |  |  |  |  |  |  |  | Strokes |  |  |  |  |  |  |  |
| Cancer (other list below) |  |  |  |  |  |  |  | Thyroid Disorders |  |  |  |  |  |  |  |
| Colon Polyps |  |  |  |  |  |  |  | Tuberculosis |  |  |  |  |  |  |  |
| Depression |  |  |  |  |  |  |  | Other: |  |  |  |  |  |  |  |
| Diabetes, Type 1 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |
| Diabetes, Type 2 |  |  |  |  |  |  |  |  |  |  |  |  |  |  |  |

Health card number and version code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name: Date:

# SOCIAL HISTORY:

**Tobacco Use Alcohol Use**

Please check one Do you drink alcohol? □ Y □ N

□ I have never smoked □ never □ occasionally □ regularly

* I have smoked, but rarely Average # drinks/week? 5 oz. wine

When was the last time?

12 oz. beer

1.5 oz. hard liquor

* I have quit smoking. Quit Date: Is alcohol use a concern for you or others? □ Y □ N

How many packs/day? How many yrs?

* I currently smoke pack(s)/day.

How many yrs.

Other Tobacco: □ pipe □ cigar □ snuff □ chew **Drug Use**

Are you interested in quitting? □ Y □ N Do you use recreational drugs? □ Y □ N Have you ever used needles? □ Y □ N

# Sexual History

Are you sexually active? □ Y □ N □ Not currently Current sexual partner(s) is/are □ male □ female Birth control method:

Have you ever had any sexually transmitted diseases (STD’s)? □ Y □ N Date: Are you interested in being screened for sexually transmitted diseases? □ Y □ N

Which STD?

**Socioeconomics**

Marital Status: □ single □ married □ separated □ divorced □ widow

Occupation: