Personal Medical History

☐ Yes ☐ No Alcoholism
☐ Yes ☐ No Allergies/Hay Fever
☐ Yes ☐ No Anemia
☐ Yes ☐ No Anxiety
☐ Yes ☐ No Asthma
☐ Yes ☐ No Atrial Fibrillation
☐ Yes ☐ No Blood Transfusions
☐ Yes ☐ No CAD
☐ Yes ☐ No Cancer
☐ Yes ☐ No Cardiac Pacer
☐ Yes ☐ No Cardiovascular Disease
☐ Yes ☐ No CHF
☐ Yes ☐ No Cirrhosis
☐ Yes ☐ No Colitis
☐ Yes ☐ No COPD
☐ Yes ☐ No CRF
☐ Yes ☐ No Crohn's Disease
☐ Yes ☐ No CVA
☐ Yes ☐ No DVT
☐ Yes ☐ No Depression

☐ Yes ☐ No Diabetes Type 1
☐ Yes ☐ No Diabetes Type 2
☐ Yes ☐ No Epilepsy
☐ Yes ☐ No Fracture
☐ Yes ☐ No Gastric Ulcer
☐ Yes ☐ No Gastrointestinal Disease
☐ Yes ☐ No GERD
☐ Yes ☐ No Gestational Diabetes
☐ Yes ☐ No Glaucoma
☐ Yes ☐ No Heart Murmur
☐ Yes ☐ No Hepatitis
☐ Yes ☐ No High Cholesterol
☐ Yes ☐ No Hyperlipidemia
☐ Yes ☐ No Hypertension
☐ Yes ☐ No Hyperthyroidism
☐ Yes ☐ No Hypothyroidism
☐ Yes ☐ No Insulin Pump
☐ Yes ☐ No Joint Pain
☐ Yes ☐ No Kidney Infections
☐ Yes ☐ No Kidney Stones

☐ Yes ☐ No Migraine
☐ Yes ☐ No Multiple Sclerosis
☐ Yes ☐ No Obesity
☐ Yes ☐ No Old MI
☐ Yes ☐ No Osteoarthritis
☐ Yes ☐ No Osteoporosis
☐ Yes ☐ No Pneumonia
☐ Yes ☐ No Progressive Neuro Disorder
☐ Yes ☐ No Pulmonary Disease
☐ Yes ☐ No Rheumatic Fever
☐ Yes ☐ No Rheumatoid Arthritis
☐ Yes ☐ No Skin Cancer
☐ Yes ☐ No STD
☐ Yes ☐ No Terminal Illness
☐ Yes ☐ No Thyroid Disease
☐ Yes ☐ No TIA
☐ Yes ☐ No Tuberculosis
☐ Yes ☐ No Valvular Problems

Other Health Issues ____

Hospitalizations

____

____

Social History

Smoking Status (Circle Below)

1. Current everyday Smoker
2. Former Smoker - Date Quit Smoking ____________
3. Heavy tobacco Smoker
4. Light tobacco Smoker
5. Never Smoked

Yes	No	N/A	Counseling on Tobacco Cessation
Yes	No	N/A	Prescription Therapy for Tobacco Cessation

Smoked for how many years ________________ Number of Packs per day ______________

Patient Initials _________

Alcohol Use (circle one)

1. Non-Drinker
2. Occasional
3. Social Drinker
4. Moderate consumption
5. Heavy Consumption
6. Beer Drinker
7. Wine Drinker
8. Recovering Alcoholic
9. Never Drank

Caffeine Use

Servings per day (circle one) 0 1 2 3 4+ Occasional

Street Drug Use

Type: ______________________________ Status: 1. Occasional 2. Daily 3. Prior Use

Surgical/Procedures

☐ No Prior surgical history

☐ Appendectomy ☐ Gall Bladder ☐ Myomectomy

☐ Breast Lumpectomy ☐ Heart Surgery ☐ Oophorectomy

☐ Cataract Surgery ☐ Hemorrhoids ☐ Ostomy

☐ Colectomy ☐ Hernia ☐ Splenectomy

☐ Cone Biopsy ☐ Joint Replacement ☐ Tonsil/Adenoidectomy

☐ D&C ☐ Laparoscopy ☐ Tubal Ligation

☐ Endometrial Ablation ☐ Mastectomy

Other Surgical History: ____

Gyn History____: Pregnancies: Live Births: ______________________________

Family Health History

Please list below the health history of your blood (genetic) first degree relatives

Relative	Living or deceased	Current age or age at death	Cause of Death	Health Problems
Father:				
Mother:				
Brother(s):				
Sister(s):				

Patient Initials __________

Please List ALL Medications Below

Medication	Dose/Directions	Quantity

Please list anything you are allergic to (medications, food, bee stings, etc.) and how it affects you.

Allergies	Reaction
1.	
2.	
3.	
4.	
5.	
6.	

7. No Known Allergies

Patient Initials ___________

Diseases Prevention and Health Maintenance

Please list below the most recent dates of your vaccines and health screening tests. Please enter the most recent date that you had the following, please be as specific as possible noting a minimum of the month and year.

Vaccine or Health Screen	Date	Vaccine or Health Screen	Date	Vaccine or Health Screen	Date
Flu Vaccine		Mammogram		Pneumovax 23	
Pneumonia Vaccine		Pap Smear		Sleep Study	
Prevnar 13 Vaccine		Colonoscopy		Endoscopy (EGD)	
Tetanus Vaccine		Bone Density (DEXA) Scan		Heart Stress Test	
Shingles (Zostovax) Vaccine		EKG		Ab Aneurysm Screen	
Shingrix Vaccine		Chest X-Ray		Abdominal Ultrasound	
DTAP Vaccine		Diabetic Eye Exam		Routine Eye Exam	
Hearing Test					

Please list the following and provide any supporting documentation.

Health Proxy ____

Advanced Directives ____

Do you have a Medical Power of Attorney? Yes / No

If Yes who? ____________________________ POA Phone #: ____________________________

____

Print Name of Patient

Patient or Guardian Signature: ___________________________ Date: _________________________

 Patient Initials __________