Name:_____ DOB:_____ Date:_____

Medications

Name	Dosage	How Often Taken

Pharmacy of Choice: _____

Medication Allergies

Name of Medication	Reaction

PAST MEDICAL HISTORY:

- ☐ Allergies
- ☐ Anemia
- ☐ Angina (chest pain)
- ☐ Asthma
- ☐ Anxiety
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Benign Prostatic Hypertrophy
- ☐ Blood Clots
- ☐ Cancer: (type)_____
- ☐ Cerebrovascular Accident
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Gallbladder Disease
- ☐ GERD
- ☐ Hepatitis C
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Irritable Bowel Syndrome
- ☐ Liver Disease
- ☐ Migraine headaches
- ☐ Myocardial Infarction (Heart Attack)
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Renal Disease
- ☐ Seizure Disorder
- ☐ Thyroid Disease

Other:

Genitourinary: Women

Age of first period	
First day of last period	
Date of last PAP	
Number of pregnancies	
Number of children	

PAST SURGICAL HISTORY: Please include date/year of service if known

- ☐ Angioplasty
- ☐ Angio with stent
- ☐ Appendectomy
- ☐ Arthrocopy Knee
- ☐ Back Surgery
- ☐ CABG
- ☐ Carpal Tunnel Release
- ☐ Cataract Extraction
- ☐ Cholecystectomy
- ☐ Colectomy
- ☐ Gastric Bypass
- ☐ Hernia Repair
- ☐ Hip Replacement
- ☐ Knee Replacement
- ☐ LASIK
- ☐ Liver Biopsy
- ☐ ORIF
- ☐ Pacemaker
- ☐ Small Bowel Resection
- ☐ Thyroidectomy
- ☐ Tonsillectomy
- ☐ Augmentation
- ☐ Mammplasty (breast enlargement)
- ☐ Bilateral Tubal Ligation
- ☐ Breast Biopsy
- ☐ Cesarean Section
- ☐ D&C
- ☐ Hysterectomy
- ☐ Mastectomy
- ☐ Breast reduction
- ☐ Vaginal hysterectomy
- ☐ TAH/BS

Other Surgeries:

FAMILY HISTORY: Please indicate relation

- ☐ ADD/ADHD
- ☐ Alcoholism
- ☐ Allergies
- ☐ Alzheimer's
- ☐ Asthma
- ☐ Blood Disease
- ☐ CAD
- ☐ CAD-Premature
- ☐ Cancer _____
- ☐ Stroke
- ☐ Depression
- ☐ Development delay
- ☐ Diabetes
- ☐ Eczema
- ☐ Hearing Deficiency
- ☐ Hyperlipidemia
- ☐ Hypertension
- ☐ Irritable Bowel
- ☐ Learning Disability
- ☐ Mental Illness
- ☐ Migraines
- ☐ Obesity
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ PVD
- ☐ Renal Disease
- ☐ Seizures Disorder

OTHER:

_____

_____

_____

SOCIAL HISTORY:

Primary Language_____ Country of Birth_____

Hand Dominance: Right Left Both

Highest Level of Education_____ Marital Status_____

Previously widowed: Yes No Previously Divorced: yes no

Children: #Girls_____ #Boys_____

Who lives in Residence_____?

Who is your support network _____?

Who may we release your medical information
to_____
_____
_____

Alcohol: Please circle

Do you drink: Yes No Formerly

If so what kind: Beer Wine Hard Liquor

How much: _____

When was your last drink: _____

Tobacco: Please circle

Smoker Status: Current Every Day Current Some Days Smoker Never Smoker Former Smoker

What Type of Tobacco: Chew Cigar Pipe Cigarettes Smokeless Snuff

Packs/Daily: _____

Years Used: _____

Ever Tried to Quit: Yes No

Caffeine: Please circle

Soda Tea Coffee Energy Drinks

How much per day: 8oz 16oz 24oz 32oz 32oz or more