

Name: _____ D.O.B. _____ Age: _____ Physician: _____

MEDICATION ALLERGIES: _____ **NONE:** _____

IMMUNIZATIONS:
LAST TETANUS _____ (Year)
Up to Date? Yes _____ **No** _____
Childhood Immunizations Up to Date?
Yes _____ **No** _____

Your Medical History:

- Diabetes controlled by;
 - Diet
 - Pills
 - Insulin
- Heart attack (date: _____)
- Other heart disease (type: _____)
- High blood pressure
- High cholesterol
- Stroke
- Seizures
- Cancer (type: _____)
- Asthma
- Emphysema
- Other _____
- Other lung disease (type _____)
- Arthritis (type: _____)
- Auto immune disease (type: _____)
- Glaucoma
- Stomach ulcers
- Reflux / Heartburn
- Gallstones
- Other stomach illness (type: _____)
- Hepatitis (type: _____)
- HIV/AIDS
- Kidney disease (type _____)
- Depression/anxiety
- Alcoholism
- Obesity

Please list all hospitalizations and surgeries – include dates if known:

Medications: Please list all medications you are currently taking, include doses and over the counter meds.

1) Med: _____ Strength: _____ Times/Day: _____	6) Med: _____ Strength: _____ Times/Day: _____
2) Med: _____ Strength: _____ Times/Day: _____	7) Med: _____ Strength: _____ Times/Day: _____
3) Med: _____ Strength: _____ Times/Day: _____	8) Med: _____ Strength: _____ Times/Day: _____
4) Med: _____ Strength: _____ Times/Day: _____	9) Med: _____ Strength: _____ Times/Day: _____
5) Med: _____ Strength: _____ Times/Day: _____	10) Med: _____ Strength: _____ Times/Day: _____

Family History

Relative	Alive Y or N (circle)	Age (if deceased, age at death)	Cause of Death	Illnesses
Mother	Y N			
Father	Y N			
<input type="checkbox"/> Brother <input type="checkbox"/> Sister	Y N			
<input type="checkbox"/> Brother <input type="checkbox"/> Sister	Y N			
<input type="checkbox"/> Brother <input type="checkbox"/> Sister	Y N			

Social History:

Employment? Occupation _____ Retired _____ Unemployed _____
 Marital status? Single _____ Married _____ Divorced _____ Widowed _____
 Do you smoke? No _____ if Yes, _____ #packs/day. If Quit when _____ # years smoked _____ packs/day _____
 Drink alcohol? No _____ if Yes, _____ Type _____ Quantity _____
 Use any illicit Drugs? No _____ if Yes, _____ Type _____ How often? _____