Name_____ DOB _____

Reason for visit

_____

Medications currently taking, dose and prescriber

_____

_____

_____

_____

Allergies and reaction if known

_____

Social History: Check or circle appropriate answer

Married ____ Single _____ Long Standing Relationship _____ Divorced _____ Other _____

Live with: Spouse _____ Children _____ Parent(s)_____ Other _____

Alcohol use: YES _____ NO _____

Amount Used: Daily _____ Weekly _____ Rarely _____ Never _____

Tobacco Use: YES, Current _____ YES, In Past _____ Second Hand Exposure _____Never ____

Ave Amount used _____ Circle Type used: cigarettes cigars pipe chewing snuff

Start date or age _____ Stop date or age _____

Seat Belt Use: YES _____ NO _____

Exercise: NO_____YES _____ Amount/type _____

Occupation: _____

Past Medial History

Check if you have ever had and explain below

High blood pressure _____	Chest Pain _____	Palpitations _____
Heart Disease or Attack _____	High cholesterol _____	Stroke _____
Diabetes _____	Thyroid disorders _____	Blood disorders _____
Asthma _____	Allergies _____	Emphysema _____
Shortness of Breath _____	Pneumonia _____	Chronic Bronchitis _____
Stomach Issues _____	Heartburn _____	Liver Problems _____
Blood in your bowels _____	Constipation _____	Chronic Diarrhea _____
Urinary Problems _____	Blood in urine _____	Cancer _____
Kidney Stones _____	Skin Problems _____	Seizures/Fainting _____
Hearing Loss _____	Vision Issues _____	Nerve Problems _____
Bone or Joint Problems _____	Mood Disorders _____	

Explain: _____

_____

Surgery History—list with approximate date or age at surgery

_____

_____

_____

Family History

	Heart Disease/ High Blood Pressure	Diabetes	Cancer	Thyroid	Other
Mother	_____	_____	_____	_____	_____
Father	_____	_____	_____	_____	_____
Brother(s)	_____	_____	_____	_____	_____
Sister(s)	_____	_____	_____	_____	_____
Child(ren)	_____	_____	_____	_____	_____
Maternal GP	_____	_____	_____	_____	_____
Maternal GM	_____	_____	_____	_____	_____
Paternal GP	_____	_____	_____	_____	_____
Paternal GM	_____	_____	_____	_____	_____
Uncle(s)	_____	_____	_____	_____	_____
Aunt(s)	_____	_____	_____	_____	_____

Health History for ADULTS

Has your cholesterol been checked in the last 5 years? YES _____ NO _____

Was it normal? YES _____ NO _____ Unknown _____

Have you had a tetanus booster within the last 10 years? YES _____ NO _____

Have you had a flu vaccine within the last year? YES _____ NO _____

Have you had the Hepatitis B Vaccine? YES _____ NO _____

If you are over 50 years, have you had a colonoscopy done within the last 10 years?

YES _____ NO _____

Was it normal? YES _____ NO _____ Unknown _____

If you are a female over 18 years, have you had a Pap smear within the last year?

YES _____ NO _____

Was it normal? YES _____ NO _____ Unknown _____

When was your last menstrual period? _____

If you are a female over 40 years, have you had your mammogram within the last year?

YES _____ NO _____

Was it normal? YES _____ NO _____ Unknown _____