

Name: _____ Date: _____ Age: _____ Date of Birth: _____

Past Medical History: *Check box if you have ever had:*

<input type="checkbox"/> breast mass	<input type="checkbox"/> diabetes	<input type="checkbox"/> colon polyp	<input type="checkbox"/> blood transfusion	<input type="checkbox"/> miscarriage
<input type="checkbox"/> breast biopsy	<input type="checkbox"/> high blood sugar	<input type="checkbox"/> diverticulitis	<input type="checkbox"/> cancer	<input type="checkbox"/> pregnancy problems
<input type="checkbox"/> heart disease	<input type="checkbox"/> underactive thyroid	<input type="checkbox"/> uterine fibroids	<input type="checkbox"/> benign tumor	<input type="checkbox"/> cataracts
<input type="checkbox"/> angina	<input type="checkbox"/> overactive thyroid	<input type="checkbox"/> ovarian cyst	<input type="checkbox"/> migraines	<input type="checkbox"/> depression
<input type="checkbox"/> heart murmur	<input type="checkbox"/> osteopenia	<input type="checkbox"/> endometriosis	<input type="checkbox"/> stroke	<input type="checkbox"/> anxiety
<input type="checkbox"/> high blood pressure	<input type="checkbox"/> osteoporosis	<input type="checkbox"/> herpes	<input type="checkbox"/> neurologic problem	<input type="checkbox"/> asthma
<input type="checkbox"/> high cholesterol	<input type="checkbox"/> low vitamin D	<input type="checkbox"/> HPV	<input type="checkbox"/> broken bones	<input type="checkbox"/> emphysema
<input type="checkbox"/> birth defect	<input type="checkbox"/> hearing loss	<input type="checkbox"/> STD	<input type="checkbox"/> arthritis	<input type="checkbox"/> tuberculosis
<input type="checkbox"/> skin cancer	<input type="checkbox"/> seasonal allergies	<input type="checkbox"/> anemia	<input type="checkbox"/> tendinitis	<input type="checkbox"/> prostate problems
<input type="checkbox"/> psoriasis	<input type="checkbox"/> ulcer	<input type="checkbox"/> bleeding problems	<input type="checkbox"/> gout	<input type="checkbox"/> kidney stones

List all other health problems and all surgeries below (include cosmetic, dental and eye surgery):

Immunizations: *Record the approximate date of the following vaccines if given during adult years.*

tetanus _____ influenza (flu) _____ pneumonia _____ HPV _____ rubella (MMR) _____

hepatitis B _____ hepatitis A _____ meningitis _____ shingles _____ other _____

Answer only if over 50yrs of age: have you ever had a **colonoscopy**? No Yes
(when) _____

Medicines: *List all medicines you are taking, include non-prescription medicines, supplements and vitamins also. List strength (milligrams) and doses per day*

Are you allergic to any medication? No Yes If yes, please list drug and reaction _____

Family Medical History: List any significant health problems for the family members listed below.

Mother: _____ Father _____

Sister: _____ Brother: _____

Mother's mother: _____ Father's mother: _____

Mother's father: _____ Father's father: _____

Has anyone in your family had **colon polyps**? No Yes **colon cancer**? No Yes **breast cancer**? No Yes
melanoma? No Yes **ovarian cancer**? No Yes **prostate cancer**? No Yes **Heart disease**? No Yes

List any other significant health problems that run in your family: _____

Women only: Menopausal? Yes No If yes, age of menopause _____ Year of last Pap _____ last mammogram _____

Do you use birth control? No Yes, method _____ How many children do you have? _____

Number of pregnancies _____ Number of live births _____ Complications? No Yes

Name: _____ Date: _____

Local preferred pharmacy (chain and street/neighborhood): _____

Marital Status: Married Single Divorced Widow(er)

Which best describes your sexual orientation: heterosexual homosexual bisexual

Are you sexually active? No Yes If yes, are you in a monogamous relationship? No Yes

Have you ever smoked? No Yes If yes, how many packs per day? _____

If you used to smoke, at what age did you start _____ Age you quit? _____

Do you drink alcoholic beverages? No Yes How much and how often? _____

Do you ever use drugs or prescription medications recreationally? No Yes If yes, please be specific _____

Do you follow any special diet? No Yes If yes, please be specific. _____

Do you exercise regularly? No Yes If so what kind and how frequently. _____

Do you have a living will or health care surrogate? No Yes Decision maker if you are unable? _____

Highest level of education: grade school high school vocational training college post-graduate degree

What kind of work do you do? _____ Religion: _____

Review of Systems: Check box if you have recently experienced any of the following.

<input type="checkbox"/> Poor appetite	<input type="checkbox"/> Problems swallowing	<input type="checkbox"/> Changes in moles	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Bloody stools	<input type="checkbox"/> New moles	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Fatigue	<input type="checkbox"/> Abdominal pain	<input type="checkbox"/> Rash	<input type="checkbox"/> Crying spells
	<input type="checkbox"/> Change in bowel habits	<input type="checkbox"/> Itching	<input type="checkbox"/> Sadness
<input type="checkbox"/> Poor vision			<input type="checkbox"/> Insomnia
<input type="checkbox"/> Eye pain	<input type="checkbox"/> Blood in urine	<input type="checkbox"/> Headache	<input type="checkbox"/> Physical abuse
	<input type="checkbox"/> Urine leakage/incontinence	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Feeling unsafe
<input type="checkbox"/> Persistent hoarseness	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Fainting	<input type="checkbox"/> Emotional abuse
<input type="checkbox"/> Hearing problems	<input type="checkbox"/> Painful urination	<input type="checkbox"/> Problems walking	
	<input type="checkbox"/> Difficulty getting stream started		<input type="checkbox"/> bleeding excessively
<input type="checkbox"/> Lump in breast		<input type="checkbox"/> Joint or bone injury	<input type="checkbox"/> blood clotting
<input type="checkbox"/> Breast discharge	Women only	<input type="checkbox"/> Painful muscles	<input type="checkbox"/> bruising for no reason
	<input type="checkbox"/> Vaginal discharge	<input type="checkbox"/> Muscle weakness	
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Pelvic pain	<input type="checkbox"/> Swollen joints	<input type="checkbox"/> allergy symptoms
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Change in periods		<input type="checkbox"/> frequent infections
<input type="checkbox"/> Swelling of the legs		<input type="checkbox"/> Excessive thirst	<input type="checkbox"/> itchy eyes
	Men only	<input type="checkbox"/> Always too warm	
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Poor erections/impotence	<input type="checkbox"/> Always too cold	
<input type="checkbox"/> Persistent Cough	<input type="checkbox"/> Discharge from penis	<input type="checkbox"/> Abnormal weight gain	
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Lump in testicles	<input type="checkbox"/> Abnormal weight loss	

Office use

Reviewed: _____ Date: _____