PERSONAL AND MEDICAL HISTORY **DATE** _____

NAME _____ DATE OF BIRTH _____

IF NEW PATIENT REFERRED BY _____

PRIMARY CONCERN AT PRESENT: _____

_____

DO YOU HAVE LIVING WILL & DESIGNATED POWER OF ATTORNEY? _____

IF YES, WHO IS RESPONSIBLE _____

PAST HISTORY (circle if yes)

MEDICAL	HOW LONG/WHEN
❑ Allergies	
❑ Angina	
❑ Anxiety	
❑ Arthritis	
❑ Asthma	
❑ Cancer	
❑ Depression	
❑ Diabetes	
❑ Gout	
❑ Heart Attack	
❑ Heart Failure	
❑ Heart Valve Problems	
❑ High Blood Pressure	
❑ High Cholesterol/Fats	
❑ Kidney Disease	
❑ Lung Disease	
❑ Migraines	
❑ Stroke	
❑ Thyroid Disease	
❑ OTHER	

MAJOR ILLNESS-HOSPITALIZATION		
	TYPE	WHEN
SURGERY		**YEAR**
❑ Adenoids/Tonsils		
❑ Appendix		
❑ Bowel		
❑ Cataracts R L		
❑ Gallbladder		
❑ Heart		
❑ Hemorrhoids		
❑ Hernia		
❑ Hysterectomy		
❑ Ovaries		
❑ Prostrate		
❑ OTHER		

SOCIAL HISTORY

MARITAL STATUS -S-M-D-W

Occupation

Children Y N How Many

Exercise Y N Type

How often

Smoking Y N How much

Alcohol Y N Type

How much

Caffeine Y N Type

How much

SCREENING TESTS		DATE
Bone Density	Y N	
Mammogram	Y N	
Pap Smear	Y N	
Prostate Exam	Y N	
PSA	Y N	
Sigmoidoscope	Y N	
Stool for blood	Y N	
Colonoscopy	Y N	

MEDICATION ALLERGIES

NAME	TYPE OF REACTION

FAMILY HISTORY

	If Living		If Deceased	
	Age	Health	Age at Death	Cause
Father				
Mother				
Brothers/Sisters (circle sex)				
M F				
M F				
M F				
M F				

Any blood relatives with: (circle and give relationship)

Cancer	Diabetes
Heart Disease	High BP
Stroke	Aneurysm
Blood Clots	Migraines
Other	

IMMUNIZATIONS

DATE

FLU _____ Y N _____
HEPATITIS A _____ Y N _____
HEPATITIS B _____ Y N _____
PNEUMONIA _____ Y N _____
TETANUS/DIPHTERIA ____ Y N _____
OTHER _____ _____

VITAMINS, HERBS, SUPPLEMENTS

INCLUDE DOSES AND HOW MANY TIMES TAKEN PER DAY

MEDICATIONS – PRESCRIPTION AND OVER THE COUNTER

MEDICATION	DOSE AND FREQUENCY	MEDICATION	DOSE AND FREQUENCY

SYSTEM REVIEW – AT PRESENT DO YOU HAVE ANY PROBLEMS WITH OR CONCERNS ABOUT YOUR:

circle answer and describe if needed

HEAD – Headaches, hair, other _____ Y N _____
EARS – Hearing, ringing, wax, other _____ Y N _____
EYES – Glasses, glaucoma, cataracts _____ Y N _____
SINUSES/NOSE – _____ Y N _____
THROAT/TEETH/MOUTH – _____ Y N _____
NECK – Lumps, thyroid, pain, other _____ Y N _____
LUNGS – Breathing, cough, other _____ Y N _____
HEART – Pain, palpitations, other _____ Y N _____
BREASTS/CHEST – _____ Y N _____
ESOPHAGUS – Heartburn, trouble swallowing, other _____ Y N _____
ABDOMEN – Constipation, diarrhea, blood, pain, gas, other ___ Y N _____
BLADDER/KIDNEYS – Difficulty with urination, blood other ___ Y N _____
SEXUAL ORGANS/FUNCTION – _____ Y N _____
EXTREMITIES – Arthritis, circulation, pains, other _____ Y N _____
SPINE/BACK – Pain, curvature, other _____ Y N _____
NERVOUS SYSTEM – Weakness, numbness, other _____ Y N _____
ANXIETY/DEPRESSION – _____ Y N _____
STRESS/WORRIES – _____ Y N _____
SKIN – Dryness, moles, rash, other _____ Y N _____
OTHER CONCERNS – _____ Y N _____
FOR WOMEN – Menstrual difficulties_Y N_____ Last menstrual period_____ Menopause_Y N When _____
Birth Control _____
FOR MEN – Testicular Lumps_Y N_____ Prostate difficulties_Y N_Describe _____

ADDITIONAL COMMENTS OR CONCERNS _____