



Name _____ SS# _____ Date _____
 Address _____ Occupation _____
 Phone (home) _____ (work) _____ Date of birth _____ Age _____
 Chief complaint _____

DRUG ALLERGIES

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

CURRENT MEDS

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

WOMEN ONLY: Pregnant? Yes No Planning pregnancy Yes No

MEDICAL HISTORY

- | | | |
|--|---|--|
| <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Lactose intolerance _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Shortness of breath _____ | <input type="checkbox"/> Gallbladder disease _____ | <input type="checkbox"/> Gout _____ |
| <input type="checkbox"/> Heart Palpitations _____ | <input type="checkbox"/> Prostate disease _____ | <input type="checkbox"/> Scarlet fever _____ |
| <input type="checkbox"/> Heart murmur _____ | <input type="checkbox"/> Bowel irregularity _____ | <input type="checkbox"/> Chronic rashes _____ |
| <input type="checkbox"/> Chest pain _____ | <input type="checkbox"/> Incontinence _____ | <input type="checkbox"/> Rheumatic fever _____ |
| <input type="checkbox"/> Dizziness/Fainting _____ | <input type="checkbox"/> Sexual/menstrual dysfunction _____ | <input type="checkbox"/> Mumps _____ |
| <input type="checkbox"/> Peripheral vascular disease _____ | <input type="checkbox"/> Venereal disease _____ | <input type="checkbox"/> Measles _____ |
| <input type="checkbox"/> Allergies/Hay fever _____ | <input type="checkbox"/> Frequent infections _____ | <input type="checkbox"/> Rubella _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Polio _____ |
| <input type="checkbox"/> Bronchitis _____ | <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Diphtheria _____ |
| <input type="checkbox"/> Pneumonia _____ | <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Tetanus _____ |
| <input type="checkbox"/> Ulcer _____ | <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> GI disorder _____ | <input type="checkbox"/> Nervousness _____ | <input type="checkbox"/> Other _____ |

HABITS

- | | | |
|--|---|---|
| <input type="checkbox"/> Smoke: Packs daily _____
How long? _____
Interested in stopping? <input type="checkbox"/> | <input type="checkbox"/> Coffee: Cups daily _____
Other caffeine _____ | <input type="checkbox"/> Sleep: Difficulty falling asleep _____
Continuity disturbances _____
Snoring _____
Early morning awakening _____
Daytime drowsiness _____
Other _____ |
| <input type="checkbox"/> Exercise Routine _____ | <input type="checkbox"/> Alcohol: Type _____
Amount _____ | |
| | <input type="checkbox"/> Diet: Salt intake _____
Fat intake _____ | |

HEPATITIS C RISK FACTOR

- | | | |
|--|--|--|
| <input type="checkbox"/> Blood transfusion prior to 1992 | <input type="checkbox"/> Contact with blood/body fluid | <input type="checkbox"/> Shared razor/toothbrush |
| <input type="checkbox"/> IV drug use (1+ times) | <input type="checkbox"/> Tattoos | <input type="checkbox"/> Body piercing |

VACCINE	YEAR OF LAST	TEST/EXAM	YEAR OF LAST
Tetanus	_____	Rectal/Stool	_____
Flu	_____	Cholesterol	_____
Pneumonia	_____	Tuberculosis	_____
Other	_____	Other	_____