Full Name_____ Birth date _____ Today's date _____

Please list all Allergies:

Allergy	Reaction	Allergy	Reaction

Please list all medications you are currently taking:

Name of medication	Amount (dose)	How long?	Doctor's Name	For what reason?

Medical History Main Problems (1) _____ (2) _____ (3) _____

Check each area and indicate age when you had any of the following symptoms or diseases.

__Decreased Hearing
__Ringing in ear
__Ear infections – recent
__Dizzy Spells
__Failing Vision
__Double or Blurred Vision
__Eye Pain
__Eye Infections – frequent
__Nose Bleeds – recurrent
__Sinus Trouble
__Sore Throats - frequent
__Hayfever/Allergies
__Hoarseness – prolonged
__Pneumonia/Pleurisy
__Bronchitis/Chronic Cough
__Asthma/Wheezing
__Shortness of breath:
__on Exertion __Lying flat
__Chest pain
__High blood pressure
__Heart Murmur
__Palpitations
__Irregular Pulse
__Swollen Ankles
__Fainting Spells

__Leg Pain when walking
__Varicose Veins/Phlebitis
__Loss of Appetite – recent
__Difficulty swallowing
__Indigestion or heartburn
__Peptic Ulcers
__Persistent nausea/vomiting
__Abdominal Pain – chronic
__Change in bowel habits-recent
__Diarrhea __Constipation
__Diverticulosis
__Bloody or tarry stools
__Hemorrhoids
__Gall bladder trouble
__Jaundice/hepatitis
__Hernia
__Urine infections – frequent
__Painful urination
__Blood in urine
__Overnight urination > twice
__Control in urination
__Decrease in force of urination
__Kidney stones
__Venereal disease (STD/STI)
__Urethral discharge

__Chronic fatigue
__Weight Loss – recent
__Anemia __Bruise easily
__Cancer
__Diabetes
__Thyroid disease
__Convulsions/seizures
__Stroke
__Tremor/hands shaking
__Muscle weakness
__Numbness/tingling sensations
__Headaches – frequent
__Arthritis/Rheumatism
__Back pain - recurrent
__Bone fracture/joint injury
__Gout
__Foot pain __Cold numb feet
__Rashes __Hives
__Psoriasis __Eczema
__Sleeping – difficulty
__Depression __Nervousness
__Memory loss
__Moodiness – excessive
__Phobias
__Mental illness

__Chicken Pox
__Measles
__Rheumatic
__Mumps
__Polio
__German Measles
__Scarlet Fever
__Tuberculosis

Other Symptoms or Diseases_____

_____

Surgical History

Date	Surgery name	Where	Doctor

Family History	If Living		If Deceased		Has any blood relative had: - note which relative	
	Age	Health	Age	Cause		
Father					Allergy/asthma	
Mother					Cancer (specify)	
Brother/ Sister					Coronary artery disease	
1.					Diabetes	
2.					High lipids	
3.					High blood pressure	
4.					Heart Attack	
5.					Stroke	
Children					Breast cancer	
1.					Colon cancer	
2.					Prostate cancer	
3.					Kidney disease	
4.					Bleeding disorder	
5.					Thyroid disease	

Immunizations **(Approx. date of last injections)**

	When		When
Tetanus	_____	Flu	_____
Pneumovac	_____	MMR	_____
Other	_____	(If born after 1957, have you had a Rubella titer or 2nd MMR)	Yes / No

Social History

Married _____ Widowed _____ Single _____ Divorced _____ If M, W, or D, how long? _____

Education Level: Grade school____yrs. High School____yrs. College____yrs. Other_____

Please describe what you do or did for a living: _____

_____

Do you now or have you in the past:		How much/ How long
Chewed tobacco, smoked pipe or cigars	Yes / No	_____
Smoked cigarettes	Yes / No	_____
Used other drugs	Yes / No	_____
Drink alcohol	Yes / No	_____

Females — Menstrual History

Age of onset: _____ Regular / Irregular Flow: Heavy / Moderate / Light

_____ Days of flow _____ Length of Cycle

Pain/ cramps with menstrual flow Yes / No

Pain/ bleeding after sex Yes / No

Number of Pregnancies _____ Number of live births _____ Number of miscarriages_____

Birth Control Method _____ B.C. Pill or IUD (name) _____

Date of last pap smear_____ Result _____

Date of last mammogram _____