

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Did a physician send you? Yes  No  Physician name: \_\_\_\_\_

Home phone number: ( ) \_\_\_\_\_ Work phone number: ( ) \_\_\_\_\_ Ext. \_\_\_\_\_

Do you have a Living Will? Yes  No  Race or nationality of parents: \_\_\_\_\_

Today's date: \_\_\_\_\_ Current age: \_\_\_\_\_ Place of birth: \_\_\_\_\_

Religion: \_\_\_\_\_ Education: \_\_\_\_\_ Occupation: \_\_\_\_\_ How Long? \_\_\_\_\_

Please describe in the space to the right your main symptoms or problems and how long you have had them.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**ALLERGIES**

Have you had allergies or sensitivity to medications or other substances? Yes  No

If yes, please list medications or other substances and describe reaction. \_\_\_\_\_

\_\_\_\_\_

**MEDICATIONS / HERBS / VITAMINS**

Medications	Dose	Frequency	Medications	Dose	Frequency
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please identify other medications you have used recently. \_\_\_\_\_

**PERSONAL MEDICAL HISTORY**

PLEASE CIRCLE ALL THAT APPLY

Diabetes / Asthma / Glaucoma / Arthritis / Hepatitis / Cancer / Stroke / Pneumonia / Tuberculosis

High Blood Pressure / Vein Trouble / Abnormal Bleeding / Rheumatic Fever / Nervous Disorder / Kidney Disease

Syphilis / Gonorrhea / Other Infections: \_\_\_\_\_

Have you ever had serious injuries, broken bones etc. Yes  No  If yes, please list: \_\_\_\_\_

Previous operations? Yes  No  If yes, list giving dates and hospital where performed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**HABITS / DRUG USE**

Do you use tobacco now? Yes  No  Type and daily amount: \_\_\_\_\_ How long? \_\_\_\_\_

Have you used tobacco in the past? Yes  No  Type and daily amount: \_\_\_\_\_ How long? \_\_\_\_\_ If stopped when? \_\_\_\_\_

Do you use alcoholic beverages? Yes  No  In the past? Yes  No  Typical amount? \_\_\_\_\_ How Long? \_\_\_\_\_

Do you use drugs? Yes  No  Type and daily amount: \_\_\_\_\_ How Long? \_\_\_\_\_ If stopped when? \_\_\_\_\_

Do relatives worry or complain about your drinking? Yes  No

How much stress do you have daily? A little  Some  A lot

Do you routinely use a seat belt? Yes  No

Are you exposed to toxic chemicals at work? Yes  No  If yes, type: \_\_\_\_\_

(CONTINUED)

**IMMUNIZATION**

(Check the diseases against which you have been immunized)

Family History		
Living (Yes/No)	Age or age At death	Present health Or cause of death
Father Yes No	_____	_____
Mother Yes No	_____	_____
Spouse Yes No	_____	_____
Brother(s) No. Living _____	_____	_____
No. Deceased _____	_____	_____
Sister(s) No. Living _____	_____	_____
No. Deceased _____	_____	_____
Children No. Living _____	_____	_____
No. Deceased _____	_____	_____

Previous marriages? – Yes / No If yes, years duration \_\_\_\_\_

Please circle illnesses, which have occurred in any of your blood relatives. - Diabetes / Stroke / Cancer / Allergies / Tuberculosis / Abnormal Bleeding / Heart Disease / Kidney Disease / High Blood Pressure / Nervous Disorder

Other: \_\_\_\_\_

Type	Yes	No	Don't Know	Had Disease	Approx. Date
Flu					
Mumps					
Measles					
Rubella (German measles)					
Tetanus (Basic Series)					
Polio (Basic Series)					
Tetanus Booster (Most Recent)					
B C G					
Pneumonia					
Hepatitis Vac.					
Other					

**MENSTRUAL HISTORY**

Age at onset \_\_\_\_\_ Last period \_\_\_\_\_ Periods are: Regular / Irregular Last Pap Smear \_\_\_\_\_ (Date)

Number of Pregnancies \_\_\_\_\_ Number of Miscarriages \_\_\_\_\_ Date(s) \_\_\_\_\_

Have you traveled or lived outside the United States and Canada? If yes, where and when. \_\_\_\_\_

Have you ever received a blood transfusion? Yes / No If yes, Date \_\_\_\_\_

**Doctors Notes:** \_\_\_\_\_

\_\_\_\_\_

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