Patient Name: _____ **Birth Date:**_____

MEDICAL HISTORY

CONDITION	YOU	LIST RELATIVE	CONDITION	YOU	LIST RELATIVE
Diabetes			Anemia		
High Blood Pressure			Leukemia		
Stroke			Sickle Cell Anemia		
Heart Attack			Bleeding Disorder		
Asthma			Stomach Ulcer		
Migraine Headaches			Mental Illness (specify)		
Cancer (specify)			Seizures		
Emphysema/COPD			Tuberculosis		
Kidney Disease			Alcoholism		
Arthritis			Suicide		
Glaucoma/Eye Problems			Skin Rash		
AIDS/HIV			Other:_____		

If adopted, Please check this box: ☐

Allergies (Medications, Food, Environmental):_____
_____.
Medications/Supplements:_____
_____.
Last Colonoscopy/ColoRectal Screening:_____
Last Bone Density Scan (DEXA): _____
Last Eye Exam:_____
Last Prostate Exam (male only):_____
Operations/Surgeries:_____
_____.
Names of other Specialists/Doctors you have seen: _____
_____.

VACCINATIONS

Vaccine:	Date of last vaccination:
Pneumonia (Prevnar or Pneumonia)	
Influenza	
Zoster (Shingles)	
Tetanus (TDaP)	
TB (Turberculosis)	

SOCIAL HISTORY

Tobacco Use: Yes No If yes, how often? _____ How long? _____
Alcohol Use: Yes No If yes, how often? _____ How long? _____
Caffeine: Yes No If yes, how often? _____ How long? _____
Drug Use: Yes No If yes, how often? _____ How long? _____
Exercise: Yes No If yes, how often? _____ How long? _____

Do you have a DO NOT RESUSCITATE status? : Yes No Do you have a living will? : Yes No

FOR WOMEN ONLY

Pregnancies(#): _____ Births(#): _____ Miscarriages(#): _____

Last Mammogram: _____ Last PAP smear: _____