TODAY'S DATE _____

NAME _____ DATE OF BIRTH _____

PATIENT HISTORY

FAMILY MEDICAL HISTORY

FAMILY MEMBER (PLEASE CHECK APPROPRIATE BOX)	ALIVE OR DECEASED (PLEASE CHECK BOX)	DATE OF BIRTH	AGE AT DEATH	MEDICAL CONDTIONS/ CAUSE OF DEATH
MOTHER	☐ALIVE ☐DECEASED			
FATHER	☐ALIVE ☐DECEASED			
☐BROTHER ☐SISTER	☐ALIVE ☐DECEASED			
☐BROTHER ☐SISTER	☐ALIVE ☐DECEASED			
☐BROTHER ☐SISTER	☐ALIVE ☐DECEASED			
☐BROTHER ☐SISTER	☐ALIVE ☐DECEASED			
☐BROTHER ☐SISTER	☐ALIVE ☐DECEASED			
☐SON ☐DAUGHTER	☐ALIVE ☐DECEASED			
☐SON ☐DAUGHTER	☐ALIVE ☐DECEASED			
☐SON ☐DAUGHTER	☐ALIVE ☐DECEASED			
☐SON ☐DAUGHTER	☐ALIVE ☐DECEASED			
☐SON ☐DAUGHTER	☐ALIVE ☐DECEASED			
MATERNAL GRANDMOTHER	☐ALIVE ☐DECEASED			
PATERNAL GRANDMOTHER	☐ALIVE ☐DECEASED			
MATERNAL GRANDFATHER	☐ALIVE ☐DECEASED			
PATERNAL GRANDFATHER	☐ALIVE ☐DECEASED			
OTHER FIRST DEGREE RELATIVE	☐ALIVE ☐DECEASED			
OTHER FIRST DEGREE RELATIVE	☐ALIVE ☐DECEASED			
OTHER FIRST DEGREE RELATIVE	☐ALIVE ☐DECEASED			

TODAY'S DATE _____

NAME _____ DATE OF BIRTH _____

SOCIAL HISTORY

DO YOU OR HAVE YOU EVER USED THE FOLLOWING?

TOBACCO	PLEASE CHECK ONE BOX EACH	DATE LAST USED	CURRENT DAILY USAGE – HOW MANY PACKS/ CIGARS/ TINS/ POUCHES PER DAY?	HOW MANY YEARS HAVE YOU BEEN USING	HOW MANY TIMES HAVE YOU ATTEMPTED TO QUIT?	WHAT HAVE YOU TRIED TO HELP YOU QUIT? NICOTINE/ ACUPUNCTURE/ COLD TURKEY/ MEDICATIONS?
CIGARETTES	☐NEVER ☐CURRENT ☐FORMER					
CIGARS	☐NEVER ☐CURRENT ☐FORMER					
PIPE	☐NEVER ☐CURRENT ☐FORMER					
CHEWING TOBACCO	☐NEVER ☐CURRENT ☐FORMER					
DIPPING TOBACCO	☐NEVER ☐CURRENT ☐FORMER					

DO YOU USE THE FOLLOWING?

ALCOHOL	PLEASE CHECK ONE BOX EACH	IF YOU DRINK SOCIALLY OR OCCASIONALLY – HOW MANY DRINKS PER MONTH?	IF YOU DRINK WEEKLY - HOW MANY DRINKS PER WEEK?	IF YOU DRINK DAILY – HOW MANY DRINKS PER DAY?
BEER	☐NEVER ☐SOCIALLY ☐OCCASIONALLY ☐WEEKLY ☐DAILY			
WINE	☐NEVER ☐SOCIALLY ☐OCCASIONALLY ☐WEEKLY ☐DAILY			
HARD LIQUOR	☐NEVER ☐SOCIALLY ☐OCCASIONALLY ☐WEEKLY ☐DAILY			

TODAY'S DATE _____

NAME _____ DATE OF BIRTH _____

DO YOU USE ANY TYPE OF RECREATIONAL DRUGS? ☐ YES ☐ NO

IF YES WHAT? _____

ARE YOU SEXUALLY ACTIVE? ☐ YES ☐ NO

IF YES DO YOU USE BARRIER PROTECTION (CONDOMS)? ☐ YES ☐ NO

DO YOU WISH TO BE SCREENED FOR SEXUALLY TRANSMITTED INFECTIONS? ☐ YES ☐ NO

HOUSEHOLD INFORMATION

WHO LIVES IN YOUR HOME WITH YOU?	
DO YOU FEEL SAFE IN YOUR HOME?	☐ YES ☐ NO
WHAT IS YOUR MARITAL STATUS?	☐SINGLE ☐DIVORCED ☐MARRIED ☐WIDOWED ☐ENGAGED
DO YOU HAVE ANY CHILDREN?	☐ YES ☐ NO
DO YOU HAVE ANY PETS?	☐ YES ☐ NO
IF YES – WHAT TYPE OF PETS?	

EMPLOYMENT INFORMATION

ARE YOU CURRENTLY EMPLOYED?	
IF NO – ARE YOU PERMANENTLY DISABLED?	
IF YES – WHO DO YOU WORK FOR?	
WHAT TYPE OF WORK DO YOU DO?	☐MANUAL LABOR ☐OFFICE WORK ☐OTHER _____
DO YOU HAVE ANY OCCUPATIONAL EXPOSURE TO HAZARDOUS MATERIALS, CHEMICALS, OR BODILY FLUIDS?	☐ YES ☐ NO IF YES – WHAT SUBSTANCES:

DO YOU SEE ANY OTHER HEALTH CARE PROVIDERS (SPECIALISTS, PHYSICAL THERAPIST, NUTRITIONIST, ETC.) ON A REGULAR BASIS?

PROVIDER'S SPECIALTY?	PROVIDER'S NAME?	WHAT DO YOU SEE THEM FOR?

TODAY'S DATE _____

NAME _____ DATE OF BIRTH _____

MEDICAL HISTORY

ARE YOU ALLERGIC TO ANY MEDICATIONS, DYES, FOODS OR OTHER SUBSTANCES? ☐ YES ☐ NO

IF YES PLEASE LIST THE SUBSTANCE AND YOUR REACTION

SUBSTANCE	REACTION (HIVES,SWELLING, DIARRHEA, PAIN, ETC.)

PREGNANCY HISTORY

TOTAL NUMBER OF PREGNANCIES	FULL TERM BIRTHS	PREMATURE BIRTHS	INDUCED ABORTIONS	SPONTANEOUS ABORTIONS (MISCARRIAGE)	ECTOPIC PREGNANCIES	MULTIPLE BIRTHS	LIVING CHILDREN

PREVENTION

PLEASE LIST THE DATE OF YOUR MOST RECENT:

INFLUENZA VACCINATION	
PNEUMONIA VACCINATION	
SHINGLES VACCINATION	
TETANUS VACCINATION	
MAMMOGRAM	
GYNECOLOGY VISIT / PAP SMEAR	
COLONOSCOPY	

TODAY'S DATE _____

NAME _____ DATE OF BIRTH _____

MEDICAL HISTORY

HAVE YOU HAD ANY SURGERIES?

SURGERY	DATE	HOSPITAL	PHYSICIAN

PLEASE LIST ANY CHRONIC MEDICAL CONDITIONS

TODAY'S DATE _____

NAME _____ DATE OF BIRTH _____

PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING INCLUDING PRESCRIPTION MEDICATIONS, OVER THE COUNTER MEDICATIONS, AND VITAMIN/DIETARY SUPPLEMENTS

MEDICATION	DOSE (MG, MCG, UNITS)	HOW MANY TIMES A DAY?

PHARMACY INFORMATION

WHAT LOCAL PHARMACY DO YOU USE?

NAME OF PHARMACY	STREET	ZIP CODE

WHAT MAIL ORDER PHARMACY DO YOU USE? _____