Date: ______________________________

Name: ____

Date Of Birth: _____________-_____________-_____________

Insurance: ____

Allergies: ____

CURRENT MEDICATIONS	**DOSE**	**HOW OFTEN?**
______________________________	________________	____________________
______________________________	________________	____________________
______________________________	________________	____________________
______________________________	________________	____________________
______________________________	________________	____________________
______________________________	________________	____________________

PAST MEDICAL HISTORY

Surgeries	Hospitalizations	Other Illnesses?
______________________________	________________	____________________
______________________________	________________	____________________
______________________________	________________	____________________
______________________________	________________	____________________

SOCIAL HISTORY	Yes	No
Have you ever smoked?	[]	[]
If yes, how long ago did you quit? ____________________		
Do you smoke?	[]	[]
If yes, how many years? ____________________ How many packs per day? ____________________		
Do you drink alcohol?	[]	[]
If yes, how many drinks on average? __________ per day __________ per week __________ per month		
Have you ever had a problem with substance abuse?	[]	[]
Have you ever injected drugs intravenously?	[]	[]
Do you drink caffinated items:	[]	[]

Soda? If yes, how much per day? ____________________

Coffee? If yes, how much per day? ____________________

Tea? If yes, how much per day? ____________________

Are you (check one):

[] Single [] Married [] Divorced [] Separated [] Widowed

If you have ever had any of these problems, please circle:

Weakness	Seizure	Breast Mass	Palpitations	Constipation
Change in Appetite	Dizziness	Asthma/Emphysema	High Blood Pressure	Change/Blood in Stool
Weight Change	Visual Changes	Shortness of Breath	Swelling	Ulcers
Rash	Deafness	Chronic Cough	Nausea/Vomiting	Chronic Nasal congestion
Anemia	Jaundice	Pneumonia	Abdominal Pain	Nasal allergies
Headache	Gallstones	Chest Pain	Diarrhea	Pain with Urination
Incontinence	Frequent Urination	Kidney Stones	Joint Pai n	Back Pain
Diabetes	Anxiety	Sleep Disturbances	Thyroid Disorder	

Continues On Back Side

	MOTHER	FATHER	SIBLING
Age (If not living age of death)			
IS THERE A HISTORY OF: (Check all that apply)			
Stroke			
Diabetes			
Hypertension			
Heart Attack			
Tuberculosis			
High Cholesterol			
Bleeder (Bleeding Problem/Anemia)			
Ulcers			
Asthma/Emphysema			
Mental Illness/ Depression			
Kidney Disease			
Cancer			

Are you aware of any other diseases in any other family member? ____

HEALTH SCREENING	YES	NO
Do you follow a low fat diet?	[]	[]
Has any Health Professional ever instructed you on a restrictive diet?	[]	[]
Do you exercise regularly?	[]	[]
Have you ever had a stool cancer check? If yes, when? _________________________	[]	[]
Have you ever had a colonoscopy? If yes, when? _________________________	[]	[]
Do you have an Advance Health Care Directive (A Living Will)?	[]	[]
When was your last Tetanus Shot? __________________________		
When was your last Pneumonia Vaccination? _________________________		
When was your last Flu Shot? __________________________		
Have you ever had a Hepatitis B Vaccination? If yes, when? ___________________________	[]	[]
Do you wear a seat belt?	[]	[]
When you ride a bike do you wear a helmet?	[]	[]
Do you have any concerns regarding AIDS or sexually transmitted disease?	[]	[]
Have you ever been diagnosed with AIDS or a sexually transmitted disease?	[]	[]
Have you ever had your cholesterol checked? If yes, when? _________________________	[]	[]
WOMEN		
Do you do self-breast exams? If yes, how often? __________________________	[]	[]
When was your last mammogram? ___________________________		
When was your last pelvic exam? __________________________ Physician Breast Exam? ___________________________		
Date of Menstrual Period? ____________________________ Number of days between periods? __________________________		
Date of Menopause? ____________________________		
Do you use birth control? If yes, what form of contraception do you use? ________________________	[]	[]
MEN		
When was you last prostate/rectal exam? _________________________		
Have you ever had a PSA? If yes, when? _______________________	[]	[]
Have you ever had problems with impotence?	[]	[]
Do you get up at night to urinate? If yes, how often? __________________________	[]	[]