

Full Name: _____

Date of Birth _____

Age _____

Drug Allergies	Current Medications

Medical and/or Family History (Please Circle all that apply)								
Allergies/Seasonal Fever	Self	Children	Diabetes	Self	Children	Osteoporosis	Self	Children
	Dad	Mom		Dad	Mom		Dad	Mom
	Sis - Bro	Grand Mom Grand Dad		Sis - Bro	Grand Mom Grand Dad		Sis - Bro	Grand Mom Grand Dad
Anemia	Self	Children	Gastro-Intestinal Disorder	Self	Children	Prostate Problems	Self	Children
	Dad	Mom		Dad	Mom		Dad	Mom
	Sis - Bro	Grand Mom Grand Dad		Sis - Bro	Grand Mom Grand Dad		Sis - Bro	Grand Mom Grand Dad
Arthritis	Self	Children	Gout	Self	Children	Prostate Cancer	Self	Children
	Dad	Mom		Dad	Mom		Dad	Uncle
	Sis - Bro	Grand Mom Grand Dad		Sis - Bro	Grand Mom Grand Dad		Brother	Grand Dad
Asthma	Self	Children	Heart Attack	Self	Children	Thyroid	Self	Children
	Dad	Mom		Dad	Mom		Dad	Mom
	Sis - Bro	Grand Mom Grand Dad		Sis - Bro	Grand Mom Grand Dad		Sis - Bro	Grand Mom Grand Dad
Breast Cancer	Self	Children	Heart Disease	Self	Children	Veneral Disease	Self	Children
	Dad	Mom		Dad	Mom		Dad	Mom
	Sis - Bro	Grand Mom Grand Dad		Sis - Bro	Grand Mom Grand Dad		Sis - Bro	Grand Mom Grand Dad
Colon Cancer	Self	Children	High Blood Pressure	Self	Children	Uterine Cancer	Self	Children
	Dad	Mom		Dad	Mom		Ant	Mom
	Sis - Bro	Grand Mom Grand Dad		Sis - Bro	Grand Mom Grand Dad		Sister	Grand Mom
Cholesterol	Self	Children	Lactose Tolerance	Self	Children	Other Cancer	Self	Children
	Dad	Mom		Dad	Mom		Dad	Mom
	Sis - Bro	Grand Mom Grand Dad		Sis - Bro	Grand Mom Grand Dad		Sis - Bro	Grand Mom Grand Dad
Chronic Rashes / Eczema	Self	Children	Anxiety / Depression	Self	Children	Other	Self	Children
	Dad	Mom		Dad	Mom		Dad	Mom
	Sis - Bro	Grand Mom Grand Dad		Sis - Bro	Grand Mom Grand Dad		Sis - Bro	Grand Mom Grand Dad

Hospitalization and/or Surgery		Social History	
Reason	Year	Smoking Yes <input type="checkbox"/> No <input type="checkbox"/> Packs/Day _____ How Long _____	
		Alcohol <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Drinks _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week	
		Caffeine <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Drinks _____ per <input type="checkbox"/> Day <input type="checkbox"/> Week	
		Exercise <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> Regular	
		Sex Active <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Trying Pregnancy <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	

Women History	
Heavy Periods <input type="checkbox"/> Irregularity <input type="checkbox"/> Pain <input type="checkbox"/> Date of Last Period ____/____/____	Age at 1st Period _____
Pain/Cramping <input type="checkbox"/> Mood Swings <input type="checkbox"/> Irritability <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> Hot Flashes <input type="checkbox"/>	
Period every _____ Days - Number of Pregnancies _____ Live Births _____ Miscarriage/Abortion _____	
Are you Pregnant Yes <input type="checkbox"/> No <input type="checkbox"/> Are you Breastfeeding Yes <input type="checkbox"/> No <input type="checkbox"/>	
Date of Last Pap Smear ____/____/____	Date of last Mammogram ____/____/____

To the best of my Knowledge the information provided above is true and correct

Patient Signature _____ Date ____/____/____