Patient Name: ____

Please List and Supply the Dates of:

Operations: ____________________ ____________________ ____________________

____________________ ____________________ ____________________

Hospitalizations Other than for Surgery: ____________________ ____________________

____________________ ____________________ ____________________

Immunization History – Have You Had: Pneumovax Immunization ☐No☐Yes When? ______

Hepatitis B? ☐No ☐ Yes When? ____ Flu Immunization? ☐ No☐ Yes When? ______

Other? ☐No ☐ Yes When? ____ Tetanus Immunization? ☐No ☐ Yes When? ______

When Was Your Last:

Pap Smear? ______________ Breast Exam? ______________ Stool Check for Blood? ____________

Mammogram? ____________ Cholesterol Check? ____________ Prostate Exam? ________________

Family History

Has Any Member of Your Family (Including Parents. Grandparents, and Siblings) Ever Had the Following?

Illness When Diagnosed	Which Family Members?	Approx. Age
Cancer (Describe Type)	____________________	__________
Hypertension (High Blood Pressure)	____________________	__________
Heart Disease	____________________	__________
Diabetes	____________________	__________
Strokes	____________________	__________
Mental Disease (Anxiety, Depression, Etc.)	____________________	__________
Drug or Alcohol Addiction	____________________	__________
Glaucoma	____________________	__________
Bleeding Diseases	____________________	__________
Other:	____________________	__________

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose

Prevention

Do You Wear Seat Belts? ☐Yes ☐No If Not, Why Not? ________________

Do You Wear a Bike Helmet? ☐Yes ☐No ☐ N/A

Do You Smoke? ☐Yes ☐ No If Yes, How Many Packs Per Day? ______

Do You Drink Alcoholic Beverages? ☐Yes ☐No If Yes, How Much Per Week? ________

Do You Drink Coffee? ☐ Yes ☐No If Yes, How Many Cups Per Day? ______

Do You Drink Tea? ☐Yes ☐No If Yes, How Many Cups Per Day? ______

If There Is a Gun in Your Home, Do You Keep it Unloaded and Out of Children's Reach? ☐Yes ☐ No N/A

Do You Use Drugs? (Marijuana, Cocaine, etc.) ☐Yes ☐No If Yes, Explain: ________________

Have You Ever Engaged in any Activity which Has Put You at Risk of Getting AIDS? ☐Yes ☐No If Yes, Explain: ________________

Do You Wish to be Tested for AIDS? ☐Yes ☐ No

Have You Ever Worked with Chemicals, Paints, Asbestos, Or Other Hazardous Material? ☐Yes ☐ No If Yes, Explain: ________________

Are You in a Relationship in Which You Have Been Physically Hurt (e.g. Slapped, Kicked, Punched, Bruised) By Your Partner? ☐Yes ☐ No

Do You Ever Feel Afraid of Your Partner? ☐Yes ☐No ☐N/A

Do You Have A "Living Will"? ☐Yes ☐No

Do You Have a Donor Card? ☐Yes ☐No

Method of Birth Control? ____

This information is for use by your physician as part of your confidential medical record.

Patient Name: ______________________________ **Age:** ______________

Address: ______________________________ **Sex:** ☐ **M** ☐ **F**

______________________________ **Home Phone:** ______________

______________________________________ **Work Phone:** _______________

Occupation: ________________________________ **Emerg. Contact:** ____________

Phone: ____________________

☐**Single** ☐**Married** ☐**Divorced** ☐**Widowed** ☐**Divorced**

If Married, Spouse's Name: ____

Children's Names and Ages: _______________________________________

Allergies to Medications, X-Ray Dyes, or Other Substances ☐ No ☐ Yes

(If Yes, Please List Names of Medicine and Type of Reaction):

__________________ __________________ __________________ __________________

__________________ __________________ __________________ __________________

__________________ __________________ __________________ __________________

Past Medical History and Review of Systems

Please Circle If You have Had Problems With, or Are Presently Complaining of Any of the Following:

1. High Blood Pressure
2. Diabetes
3. Cancer
4. Heart Disease
5. Chest Pain/Tightness
6. Shortness of Breath
7. Swollen Ankles
8. Palpitations
9. Lightheadedness
10. Frequent Urination
11. Rheumatic Fever
12. Asthma
13. Bronchitis
14. Pneumonia
15. Persistent Cough
16. T.B.
17. Hay Fever
18. Abdominal Discomfort
19. Indigestion
20. Nausea
21. Vomiting
22. Constipation
23. Diarrhea
24. Blood in Stool
25. Ulcers
26. Change in Bowel Habits
27. Unexplained Weight Gain/Loss
28. Hemorrhoids
29. Gall Bladder Disease
30. Colitis
31. Hepatitis or Jaundice
32. Thyroid Disease
33. Head or Neck Radiation
34. Constipation
35. Kidney Diseases
36. Kidney Stones
37. Difficulty Urinating
38. Arthritis
39. Low Back Problems
40. Skin Diseases
41. Blood Disorders
42. Venereal Diseases
43. Anxiety
44. Depression
45. Anemia
46. Alcohol Abuse
47. Drug Abuse
48. Gout
49. Achieve Erection
50. Maintain Erection

____

____

____

Gynecologic and Obstetric History

Age at Onset of Periods: __________ Frequency: ____________ Length of Period: ____________

Pregnancies: ________________ Births: ______________ Miscarriages: ________________

Prolonged or Abnormal Bleeding: ☐ No ☐ Yes (Please Describe): ____________________

Leakage of Urine: ☐ No ☐ Yes (Please Describe): ____________________

Pelvic Pain: ☐ No ☐ Yes (Please Describe): ____________________

Abnormal Discharge: ☐ No ☐ Yes (Please Describe): ____________________

History of Abnormal Pap Smear: ☐ No ☐ Yes (Type of Treatment): __________________

This Information is for use by your physician as part of your confidential medical record.

Please continue on next page.