NAME: _____ DATE OF BIRTH: _____

PATIENT HISTORY

PERSONAL/FAMILY PAST MEDICAL HISTORY

Have you or a family member ever had any of the following illnesses?

	PT	FAM		PT	FAM		PT	FAM
Anemia			Dementia			High Cholesterol		
Angina			Depression			Kidney Problems		
Anxiety			Dermatitis			Liver Problems		
Arthritis			Diabetes			Migraines		
Asthma			Epilepsy/Seizures			Neurological Disorder		
Back Problems			Gallbladder			Pneumonia		
Bleeding Disorder			GERD			Renal Stone		
Blindness			Glaucoma			Rheumatic Fever		
Breast Cancer			Gout			Sinus Problems		
CAD			HIV			Stroke		
CHF			Headache			Thyroid Problems		
COPD			Hearing Loss			Tuberculosis		
Cancer-Specify			Heart Problems			Ulcers		
Cataracts			Hepatitis			Cervical Cancer		
Colitis			High Blood Pressure			Other		
Auto Immune Disease			Allergies-Seasonal			Chronic UTI		

Date of last mammogram: _____ Results: _____

Date of last colonoscopy: _____ Findings: Polyp ___ Diverticuli: ____Normal: _____

Date of last Pap: _____ Results: _____

Date of last DEXA: _____ Results: _____

Last LMP: _____ Current Birth Control: _____

Age of Menopause: _____ Age of first period: _____

Last dental exam: _____ Dentist: _____

Last eye exam: _____ Optometrist: _____

SURGERIES	YEAR

MEDICATION ALLERGIES

Current Medications

Name of Medicine	Dosage	How often per day	Years of usage

NAME: _____ DATE OF BIRTH: _____

Pharmacy: _____ City: _____ Phone number: _____

Abuse (circle one)
I feel safe at home: YES NO
Is there anyone you are afraid of? YES NO
Do you have a history of abuse? YES NO

Tobacco Use: ☐ None Quit Date: _____
☐ Pipe/Cigar ☐ Cigarettes Packs/Day: _____ Number of years smoked: _____
☐ Smokeless tobacco ☐ Electronic or E-Cigarette ☐ Secondhand smoke exposure

Alcohol Use: ☐ None ☐ Daily ☐ Occasional ☐ Trying to cut ☐ In recovery ☐ Amount per week: ____

Drug Use: ☐ None ☐ Past Use ☐ Current
☐ Marijuana ☐ Amphetamines ☐ Cocaine ☐ Designer/Club
Route: ☐ Smoke ☐ Inject ☐ Ingest ☐ Topical

How many times in the past year have you used recreational drugs/prescription medication for nonmedical reasons?

☐ None ☐ One or more

IMMUNIZATIONS

Please provide any known **dates** or full immunization record(s).

Tetanus or Tetanus/Pertussis: _____ Influenza: _____ Shingles: _____ Meningitis: _____

Hepatitis A: _____/_____ Hepatitis B: _____/_____/_____

HPV: _____/_____/_____ Prevnar 13 (pneumocaccal): _____ Other: _____

SOCIAL HISTORY

Do you have a caregiver? YES NO Name: _____ Relationship: _____

Diet: ☐ Well balanced ☐ Diabetic ☐ Other special diet: _____

Weight loss products: _____ Vitamins/Herbs: _____

Exercise/Activity Level: ☐ Sedentary ☐ Strength/Wt Training ☐ Stretch/Balance
☐ 20 min/day ☐ 3 times per week ☐ Aerobic/Cardiac

With whom do you live? ☐ Alone ☐ Children ☐ Spouse/Partner ☐ Assisted Living: _____

Education: ☐ GED ☐ High School ☐ Did not complete High School ☐ College ☐ Advanced Degree ☐ Tech

Occupation: _____

Leisure Activities: _____ Religion: _____

Have you recently traveled to any foreign countries? YES NO List: _____

Do you: ☐ Use seatbelts ☐ Use a helmet ☐ Have guns in home ☐ Have smoke detector

Sexual Activity: ☐ Not active ☐ Active Number of lifetime partners: _____ ☐ Men ☐ Women ☐ Both