NAME ____ **DATE**__________________________

PAST MEDICAL HISTORY

Please check any of the following conditions that you have or have had in the past:

[ ] Anemia	[ ] Asthma	[ ] Schizophrenia
[ ] Diabetes	[ ] Emphysema	[ ] Depression
[ ] Thyroid problems	[ ] Pneumonia	[ ] Gout
[ ] Angina	[ ] Seizures	[ ] Tuberculosis
[ ] Abnormal heart rhythm	[ ] Stroke or TIA	[ ] Alcohol addiction
[ ] Heart attack	[ ] Migrane Headaches	[ ] HIV or AIDS
[ ] Heart failure	[ ] Colitis	[ ] Cancer
[ ] High blood pressure	[ ] Hepatitis	[ ] Chlamydia
[ ] Murmur	[ ] Peptic ulcer disease	[ ] Gonorrhea
[ ] Rheumatic Fever	[ ] Kidney Stones	[ ] Herpes
[ ] Elevated cholesterol	[ ] Glaucoma	[ ] Genital Warts

Do you exercise? <3x/ week >3x/ week

Do you currently smoke cigarettes? Y N

If yes, how many per day? ______________________

How many drinks of alcohol do you consume per week?

0 <6 <12 <24 >24

Level of Education? (Please circle)

High School College Graduate School

OB/GYN History (Female Patients)

# of Pregnancies? ___________ # of Miscarriages? ___________

Last Pap smear? ____________ Last Mammogram? ___________

OTHER MEDICAL HISTORY

List any other medical conditions that you have been diagnosed with:

____

____

____

____

SURGICAL HISTORY

List all surgeries that you have had:

____

____

MOTHER LIVING: Y N

Health status or cause of death:

____

FATHER LIVING: Y N

Health status or cause of death:

____

MARITAL STATUS: S M D W

CHILDREN: Y N

IMMUNIZATIONS:_________________

____

LAST TETANUS? _________________

____

Family History

Please check the appropriate family medical history:

Medical Condition	**Father**	**Mother**	**Father's parents**	**Mother's Parents**	**Siblings**
High Blood pressure	[ ]	[ ]	[ ]	[ ]	[ ]
Heart Attack	[ ]	[ ]	[ ]	[ ]	[ ]
Blood disorder	[ ]	[ ]	[ ]	[ ]	[ ]
Diabetes	[ ]	[ ]	[ ]	[ ]	[ ]
Schizophrenia	[ ]	[ ]	[ ]	[ ]	[ ]
Seizures	[ ]	[ ]	[ ]	[ ]	[ ]
Stroke	[ ]	[ ]	[ ]	[ ]	[ ]
Migrane headaches	[ ]	[ ]	[ ]	[ ]	[ ]
Asthma	[ ]	[ ]	[ ]	[ ]	[ ]
Emphysema	[ ]	[ ]	[ ]	[ ]	[ ]
Colitis	[ ]	[ ]	[ ]	[ ]	[ ]
Kidney problem	[ ]	[ ]	[ ]	[ ]	[ ]
Cancer	[ ]	[ ]	[ ]	[ ]	[ ] (Type) ________________________

Medications: ______________________________

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Allergies:__________________________