NAME _____

DATE OF BIRTH _____/_____/_____

AKA (Nickname) _____

TODAY'S DATE _____

MEDICAL HISTORY (Year diagnosed/Specialist name)

- ☐ Asthma _____
- ☐ Bladder /Kidney disorder _____
- ☐ Blood disorder _____
- ☐ Breast/GYN disorder _____
- ☐ Cancer (_____) _____
- ☐ Chronic ENT disorder _____
- ☐ Depression/Anxiety _____
- ☐ Diabetes _____
- ☐ Gastrointestinal disorder _____
- ☐ Heart Disorder _____
- ☐ High Blood Pressure _____
- ☐ High Cholesterol _____
- ☐ Lung/COPD/Emphysema _____
- ☐ Musculoskeletal disorder _____
- ☐ Neurologic/Stroke/Seizure _____
- ☐ Prostate Problem _____
- ☐ Skin disorder _____
- ☐ Thyroid disorder _____
- ☐ Other _____ _____

PAST TESTING

			Date Performed
Bone Density	☐ Y	☐ N	_____
Colonoscopy	☐ Y	☐ N	_____
EKG	☐ Y	☐ N	_____
Mammogram	☐ Y	☐ N	_____
Pap (females)	☐ Y	☐ N	_____
Prostate (males)	☐ Y	☐ N	_____
Pulmonary function	☐ Y	☐ N	_____
Stress Testing	☐ Y	☐ N	_____

SURGERIES (Type of Surgery/Date)

- ☐ Abdominal _____ ☐ Orthopedic _____
- ☐ Appendix _____ ☐ Prostate _____
- ☐ Breast _____ ☐ GYN _____
- ☐ Gall Bladder _____ ☐ Urologic _____
- ☐ Heart _____ ☐ Other _____

SOCIAL HISTORY

Single Married Widowed Divorced Separated

#Children ____ #Miscarriages ____ #Abortions ____

Occupation: _____

Years of Education/Highest Degree: _____

Tobacco Use: ☐ Cigarettes ☐ Never
☐ Pipe ☐ Quit Date _____
☐ Cigar ☐ Packs/day _____
☐ Snuff ☐ # of years _____
☐ Chew

Caffeine: ☐ Yes ☐ No ☐ Cups/day _____

Alcohol: ☐ Yes ☐ No ☐ Drinks/wk_____

Is alcohol a concern for you/others? ☐Y ☐N

Drug Use:

Have you ever used non-legalized drugs? ☐Y ☐N

Have you ever used needles to inject drugs? ☐Y ☐N

Other Concerns:

Weight: ☐Y ☐N Diet: ☐Good ☐Fair ☐Poor

Regular Exercise: ☐Y ☐N What Kind? _____

How long (minutes) _____ # _____/week

Your Safety: Is violence at home a concern? ☐Y ☐N

Have you ever been abused? ☐Y ☐N

Do you fall frequently? ☐Y ☐N

Have you completed: ☐ Living Will ☐ Durable Power of Attorney ☐ Advanced Healthcare Directive

☐ POLST ☐ Do not resuscitate order

Over the Age of 65:

Do you have any concerns about activities of daily living? _____

Do you feel you have memory issues? ☐Y ☐N

Do you feel you are at risk for falling? ☐Y ☐N

MEDICATIONS: Prescribed and over-the-counter. Include vitamins, herbs, and home remedies.

MEDICATION	DOSE	TIMES PER DAY

MEDICATION	DOSE	TIMES PER DAY

PHARMACY: What local pharmacy do you use? _____ Location _____

What mail order pharmacy do you use? _____

ALLERGIES OR REACTIONS: To medication, food, environment, or other agent.

MEDICATION, FOOD, OTHER	REACTION OR SIDE EFFECT	DATE IT OCCURRED

FAMILY HISTORY ☐ Adopted ☐ Family History Unknown

FAMILY HISTORY *Check all that apply*	Mental health disorder	Alcohol	Breast cancer	Colon cancer	Prostate/ Uterine cancer	Lung cancer	Diabetes	High Blood Pressure	High Cholesterol	Cause of Death	Other
Father											
Mother											
Maternal Grandfather											
Maternal Grandmother											
Paternal Grandfather											
Paternal Grandmother											
Brothers											
Sisters											

IMMUNIZATION HISTORY

Please note if you have had any of the immunizations below. **Please note the date.**	
DTap (Tetanus & Pertussis) ☐ Y ☐ N Date _____	Influenza (Flu) ☐ Y ☐ N Date _____
Hepatitis A Series ☐ Y ☐ N Series of 2: #1 _____ #2 _____	Pneumonia ☐ Y ☐ N Date _____
Hepatitis B Series ☐ Y ☐ N Series of 3: #1 _____ #2 _____ #3_____	Shingles ☐ Y ☐ N Date _____
HPV ☐ Y ☐ N Date _____	Tetanus ☐ Y ☐ N Date _____
Other Immunization:	