

DATE

PATIENT NAME IN FULL

M
 F

AGE

MEDICAL RECORD NUMBER

DATE OF BIRTH

MARITAL STATUS

OCCUPATION

PERSONAL AND FAMILY HISTORY

- Indicate if you or anyone in your family has (or has ever had) any of the following conditions
- If a member of your family has had one of these conditions, indicate their relationship to you

DESCRIPTION	PERSONAL		FAMILY		RELATION	DESCRIPTION	PERSONAL		FAMILY		RELATION
	YES	NO	YES	NO			YES	NO	YES	NO	
Hearing problems						High cholesterol					
Heart disease / Circulatory problems						Epilepsy or seizures					
High blood pressure						Migraine headaches					
Stroke						Arthritis or Gout					
Asthma, emphysema, bronchitis						Depression / nervous problem					
Ulcers / Digestive problems						Diabetes					
Drug / Alcohol problems						Hepatitis or liver problems					
Cancer: Breast						Thyroid disease					
Colon						Sleep apnea					
Prostate						Anemia / Blood diseases					
Other, where?						HIV / AIDS / STDs					
Kidney stones / Cysts / Failure						Tuberculosis					
Gallbladder						Osteoporosis					

SOCIAL HISTORY

INDICATE USAGE	Tobacco	<input type="checkbox"/> No <input type="checkbox"/> Yes	PACKS OR CANS PER DAY	FOR HOW MANY YEARS	DATE QUIT
	Alcoholic Beverages	<input type="checkbox"/> No <input type="checkbox"/> Yes	HOW MANY DRINKS PER WEEK		HOW MANY DRINKS PER MONTH
	Caffeinated Beverages	<input type="checkbox"/> No <input type="checkbox"/> Yes	CUPS OF COFFEE PER DAY	POP / TEA PER DAY	
TOTAL NUMBER OF CHILDREN IN HOME	Childbirth History	# OF PREGNANCIES	# MISCARRIAGES OR LOST PREGNANCIES	ANY COMPLICATIONS OF PREGNANCY	

Are you afraid of anyone at home? No Yes Do you have guns at home? No Yes Are they locked up? No Yes

HOSPITALIZATIONS / SURGERIES / DIAGNOSTIC TESTS

HOSPITALIZATION / SURGERY / DIAGNOSTIC TEST	DATE	HOSPITALIZATION / SURGERY / DIAGNOSTIC TEST	DATE

LIST ANY PRESCRIPTION OR OVER-THE COUNTER MEDICATIONS WITH DOSES YOU ARE CURRENTLY USING

MEDICATION NAME / DOSE	MEDICATION NAME / DOSE	MEDICATION NAME / DOSE

ARE YOU ALLERGIC TO ANY MEDICATIONS
 No Yes - List

IMMUNIZATIONS

TYPE OF IMMUNIZATION	DATE	OTHER IMMUNIZATIONS	DATE
Last Pneumonia			
Last Tetanus			
Last Influenza			
Last TB Skin Test			

If under 18, are immunizations current Yes No

