



Name: _____ Date of Birth _____ Sex _____ Marital Status
 S M D W
 Height _____ Weight _____ Occupation _____ Date _____

DRUG ALLERGIES

CURRENT MEDS

FAMILY HISTORY

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date

MEDICAL HISTORY

- | | | |
|--|--|---|
| <input type="checkbox"/> Allergies/Hay fever _____ | <input type="checkbox"/> Gout _____ | <input type="checkbox"/> Pneumonia _____ |
| <input type="checkbox"/> Anemia _____ | <input type="checkbox"/> Headache _____ | <input type="checkbox"/> Polio _____ |
| <input type="checkbox"/> Arthritis _____ | <input type="checkbox"/> Heart murmur _____ | <input type="checkbox"/> Prostate disease _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Heart palpitations _____ | <input type="checkbox"/> Rheumatic fever _____ |
| <input type="checkbox"/> Bowel irregularity _____ | <input type="checkbox"/> Hepatitis _____ | <input type="checkbox"/> Rubella _____ |
| <input type="checkbox"/> Bronchitis _____ | <input type="checkbox"/> Incontinence _____ | <input type="checkbox"/> Scarlet fever _____ |
| <input type="checkbox"/> Chest pain _____ | <input type="checkbox"/> Lactose intolerance _____ | <input type="checkbox"/> Sexual/menstrual dysfunction _____ |
| <input type="checkbox"/> Chronic rashes _____ | <input type="checkbox"/> Measles _____ | <input type="checkbox"/> Shortness of breath _____ |
| <input type="checkbox"/> Depression _____ | <input type="checkbox"/> Muscle aches/soreness _____ | <input type="checkbox"/> Tetanus _____ |
| <input type="checkbox"/> Diphtheria _____ | <input type="checkbox"/> Mumps _____ | <input type="checkbox"/> Ulcer _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Nervousness _____ | <input type="checkbox"/> Venereal disease _____ |
| <input type="checkbox"/> Dizziness/Fainting _____ | <input type="checkbox"/> Numbness in feet _____ | <input type="checkbox"/> Weight loss _____ |
| <input type="checkbox"/> Frequent infections _____ | <input type="checkbox"/> Numbness in hands _____ | <input type="checkbox"/> Weight gain _____ |
| <input type="checkbox"/> Gallbladder disease _____ | <input type="checkbox"/> Osteoporosis _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> GI disorder _____ | <input type="checkbox"/> Peripheral vascular disease _____ | <input type="checkbox"/> Other _____ |

Name _____ Today's Date _____

SS# _____ Date of Birth _____

SOCIAL HISTORY

Work in the home Employed (occupation _____) Student

Single Married Divorced Separated Widowed

Children No Yes #

Do you live alone? No Yes

Exercise? Daily Weekly Monthly Rarely Never

What type of exercise? _____

Are you on a special Diet? No Yes Describe _____

History of substance abuse No Yes What? _____

Smoke currently? No Yes _____ Packs per day for _____ years

Quit smoking? This year > 1 year > 5 years > 10 years

Previously smoked _____ Packs per day for _____ years

Drink alcohol? Daily 1-2 x/week 1-2 x/month 1-2 x/year

CHIEF COMPLAINT

Why are you seeing the doctor today? _____

Current problem is the result of a(n): **Check** all that apply

Car Accident Work Accident Accident

Other _____

This occurred during: **Check** all that apply

Lifting Pulling Pushing Twisting Falling Bending

Reaching Squatting Hit by Object Not known

WOMEN ONLY

Pregnant? Yes No

Planning pregnancy? Yes No

Fill in blanks

Pregnancies:
Total Number

_____ Age at onset of menstruation

_____ Pregnancies

_____ Length of cycle in days

_____ Normal live births

_____ Flow (heavy, medium, light)

_____ Stillbirths

_____ Date of onset of last period

_____ Miscarriages

_____ Age of menopause onset

_____ Cesarean sections

Reviewed By: _____ MD Date: _____