Medical History			Date:///		
Name:			DOB:/		
	Physical Problem/Esta				
	•				
Please <u>circle</u> your Marital S	tatus: Single Married	Divorced	Widowed Separated		
If married, spouses name:					
Children's Names and Ages	:				
Occupation:		Employe	r:		
Do you have any known all	ergies? Yes No Please List Allergi		eactions .		
Allergy	Reaction	Allergy	Reaction		
		<u> </u>			
Please List Drug Name	Dose	Drug Name	e-Counter, and Vitamins/Herbs Dose		
Social History (Please Che	ck)				
Do You Use a Seatbelt? \	/es No				
Do You Use Sunscreen? `	/es No				
Do You Exercise? No	Less than 3 times per we	ek: Mo	ore than 3 times per week:		
Do You Currently Smoke?	No Yes	Are you a	Former Smoker? No Yes		
	Day: Number of Ye				
Do You Consume Alcohol?					
• Drinks per	day: Drinks per w	eek:			

Name:	DOB:	' /
Ivaliic.		

Please Check if You or a Blood Relative Have Been Diagnosed with or Have Any of These Medical Conditions

Yes No

What Blood Relative? (Mother, Father, etc.)

Abnormal Pap	
Alcohol Abuse	
Anemia	
Anxiety	
Arthritis	
Asthma	
Blood Disorder	
Blood Transfusion	
Bowel Disorder (What Type?)	
Cancer (What Type?)	
Chronic Lung Disease	
Colitis	
Deep Vein Thrombosis	
Depression	
Diabetes	
Drug Abuse	
Gall Bladder Disease	
Glaucoma	
Gout	
Hay Fever	
Headaches/Migraines	
Heart Disease	
Hemorrhoids	
Hepatitis/Liver Disease	
High Blood Pressure	
Impotence/Erectile Dysfunction	
Kidney Disease	
Kidney Stones	
Rheumatic Fever	
Skin Disease	
T.B.	
Thyroid Disease	
Venereal Disease	
Other	

	Yes	No		Date
Abdominal Discomfort			Flu Vaccine	
Blood in Stool			Tetanus Vaccine	
Change in Bowel Habits			Pneumovax Vaccir	no
Chest Pain/Tightness				
Constipation			Hepatitis B Vaccino	
Diarrhea			Gardasil/HPV Vaco	cine
Difficulty Urinating			TB Skin Test	
Frequent Urination			Pap Smear	
Head/Neck Irritation			Mammogram	
Headaches				
Indigestion			Colonoscopy	
Lightheadedness	1		Bone Density	
Low Back Pain/Problems			Other	
Nausea				
Palpitations				
Persistent Cough				
Shortness of Breath				
Swollen Ankles				
Unexplained Weight Loss/Gain				
Vomiting	1			
Other				
Ple	ase List /	Any Opera	tions or Hospitalizations	
Surgery/Reason Date			Surgery/Reason	Date
ł				
				4

Name: _____