



Name:		Reason for today's visit:			
Home phone:	Work Phone:	Male <input type="checkbox"/> Female <input type="checkbox"/>	Race	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed <input type="checkbox"/> Separated	
Date of Birth:	Current Age:	Religion	Occupation:		
Education				Degree:	
Spouse's Name:		Spouse's Occupation:			

**PAST MEDICAL HISTORY**

**SURGERY (type and year)**

1.	2.	3.	4.
Other:			

**LONGSTANDING MEDICAL PROBLEMS**

1.	2.	3.	4.
Other:			

**MEDICATIONS AND DOSAGES YOU ARE CURRENTLY TAKING**

1.	2.	3.	4.
5.	6.	Other:	

**ALLERGIES**

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Tobacco:	Type	Amt.	Yrs.	Alcohol:	Beer <input type="checkbox"/> Wine <input type="checkbox"/> Liquor <input type="checkbox"/>	Have you ever had:	Y/N	Yr.
Never	Cigarettes			Never	Once a week <input type="checkbox"/>	Pap Smear?		
Quit	Cigar / Pipe			Quit	2-3 times per week <input type="checkbox"/>	Mammogram?		
	Smokeless			Rarely	Daily <input type="checkbox"/>	Tetanus immunization		
				Amount:		Pneumovax?		

**FAMILY HISTORY**

FAMILY MEMBER NAME	LIVING		DECEASED	
	AGE	HEALTH	AGE	CAUSE
Father				
Mother				
Brothers/Sisters				
Spouse				
Children				

**HAVE YOU OR A FAMILY MEMBER EXPERIENCED**

	YES	NO	WHO
Allergy / Asthma			
Anemia			
Arthritis / Gout			
Birth Defects			
Bleeding Disorder			
Cancer or Tumor			
Diabetes			
Emphysema			
Epilepsy / Convulsions			
Glaucoma			
Heart Trouble			
Hepatitis / Jaundice			
High Cholesterol			
High Blood Pressure			
Kidney or Bladder Trouble			
Mental Illness or Nervous Breakdown			
Migraine Headaches			
Sexually Transmitted Disease			
Stroke			
Thyroid			
Tuberculosis			
Ulcers			
Other			