Name:_____ DOB:_____

Primary Doctor:_____

Pharmacy: _____

Medication Allergies (also list the reaction): _____

Medications: _____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Personal Medical History

Circle all that apply

Eyes, Ears, Nose Cataracts Recurrent ear infections Glaucoma Recurrent sinusitis

Other _____

Endocrine Diabetes Hyperthyroid Graves disease Hypothyroid Parathyroid

Pituitary Calcium Problems Other _____

Respiratory Allergies/hay fever COPD Asthma Sleep Apnea

Other _____

Cardiovascular Chest Pain Heartburn Deep venous thrombosis Hypertension

Atrial Fibrillation Heart Failure Heart Attack Cardiac Arrhythmias Heart valve disease

Peripheral vascular disease Coronary artery disease High Cholesterol

Other_____

Gastrointestinal Colitis Liver disease Peptic ulcer disease GERD Pancreatitis

Irritable Bowel Other _____

Name:_____ DOB:_____

Genitourinary Kidney disease Gonorrhea Kidney failure Urinary incontinence

Genital Herpes Kidney stones Erectile dysfunction Testicular problems Undescended testicle

Prostate problems Other _____

Musculoskeletal Arthritis Gout Fractures Osteoporosis

Other _____

Cancer Type _____

Chemo Radiation Surgery Currently under Treatment Remission

Infectious Disease AIDS Chickenpox Mumps Hepatitis Tuberculosis HIV

Rheumatic Fever Other _____

Skin Acne Psoriasis Eczema Other _____

Neurologic ADHD Headaches Seizure Stroke Dementia

Peripheral Neuropathy TIA Developmental Delay Restless Leg Syndrome

Other _____

Psychiatric Anorexia nervosa Bulimia Insomnia Anxiety Depression Bipolar

Schizophrenia Other _____

Metabolic/Genetic Cystic Fibrosis Down Syndrome Turner's Syndrome Klinefleter's Syndrome

Other _____

Events Anaphylaxis MVA Gun wound Other _____

Disabilities Hearing deficit Hemiparesis Quadriplegia Vision deficit Paraplegia

Other _____

Name:_____ DOB:_____

Surgeries

Ears, Eyes, Nose

Cataract Tonsillectomy Other _____

Endocrine

Parathyroidectomy Thyroidectomy Other _____

Respiratory

Bronchoscopy Lobectomy Other _____

Cardiovascular

Angiogram Carotid endarterectomy Pacemaker Angioplasty Coronary stent

Valve Replacement CABG (Bypass) Heart Transplant

Other _____

Gastrointestinal

Appendectomy Colectomy Splenectomy Gallbladder Gastric Bypass

Other _____

Genitourinary

Bladder Nephrectomy Kidney stone Prostate TURP

Other _____

Reproductive

Vasectomy Hysterectomy Oopherectomy C-Section Tubal Ligation

Other _____

Musculoskeletal

Joint replacement: _____ Other _____

Skin

Skin cancer Other _____

Name:_____ DOB:_____

Neurologic

Craniotomy Spinal Other _____

Breast

Biopsy Mastectomy Lumpectomy Other _____

Family Medical History - list family members , relationship to you, age of onset

Diabetes - _____

Thyroid - _____

Asthma - _____

High Cholesterol - _____

Hypertension - _____

Atherosclerosis - _____

Coronary Artery Disease - _____

Cancer (type) - _____

Hepatitis B - _____

Tuberculosis - _____

Dementia - _____

Stroke - _____

Alcoholism - _____

Depression - _____

Drug abuse - _____

Mental illness - _____

Autoimmune disease - _____

Blood disorder - _____

Rheumatoid disease - _____

Hearing problems - _____

Vision problems - _____

Name:_____ DOB:_____

Tobacco Use

Current every day Current someday Former smoker, year quit _____ Never smoked

Type: Cigarette Smokeless tobacco Cigar Pipe

Alcohol

None 0-2 drinks/day 2+ drinks/day 1-2 drinks/month