MEDICAL/SOCIAL HISTORY

Name _____ **Date of Birth** _____

Allergies to Medications, X-Ray dyes, or other substances? _____NO _____YES
If yes, please list name of medicine and type of reaction:

_____

_____

_____

Past Medical History—please circle if you have had past problems with the following:

1. High Blood Pressure
2. Cancer
3. Heart disease
4. T.B.
5. Hay fever
6. Abdominal pain
7. Thyroid disease
8. Head/neck radiation
9. Headaches
10. Rheumatic fever
11. Asthma
12. Diabetes
13. Bronchitis
14. Pneumonia
15. Persistent cough
16. Gallbladder disease
17. Colitis
18. Hepatitis/Jaundice
19. Anemia
20. Alcohol Abuse
21. Drug Abuse
22 Kidney disease
23. Kidney stones
24. Blood in Stool
25. Change in bowel habits
26. Weight loss/gain
27. Hemorrhoids
28. Venereal disease
29. Anxiety
30. Depression
31. Gout
32. Ulcers
33. Difficulty urinating
34. Blood Clot (legs/lungs)
35. Stroke
36. On blood thinners
37. Arthritis
38. Low back pain
39. Blood disorder

Please List and Supply the Dates of:

Operations: _____ _____
_____ _____
_____ _____

Hospitalizations: _____ _____
_____ _____

When was your last:

Pap Smear _____ **Breast Exam** _____ **Stool check for blood** _____
Mammogram _____ **Cholesterol** _____ **Prostate Exam** _____

Patient Name _____ **Date of Birth** _____

Family History

Has any member of your family (including parents, grandparents & siblings) ever had:

Illness	Which family members?	Approximate age when diagnosed?
Cancer		
Hypertension		
Heart Disease		
Diabetes		
Stroke		
Mental disease (anxiety/depression)		
Drug/Alcohol Addiction		
Glaucoma		
Bleeding Diseases		
Other:		

Prevention

Do you wear seat belts? _____yes _____no If no, why not? _____

Do you wear a bike helmet? _____yes _____no _____not applicable

Do you exercise regularly? _____yes _____no If yes, type/duration/number of times weekly:

_____

Social History

Do you smoke?	Yes/No	Packs per day _____
Do you drink alcoholic beverages?	Yes/No	Amount per week _____
Do you drink coffee or tea?	Yes/No	Cups per day _____
Is there a gun in your home?		
If yes, is it unloaded and out of children's reach?	Yes/No	
Do you use drugs, marijuana, or other illegal drugs?	Yes/NO	
Have you ever engaged in activity making you at risk for AIDS?	Yes/NO	
Have you ever worked with chemicals, paints, Asbestos, or other hazardous materials?	Yes/No	
Are you in a relationship where you feel unsafe (slapped, kicked, punched, bruised)?	Yes/No	
Are you afraid of anyone in your home?	Yes/No	
Do you have a living will?	Yes/No	
Do you have a donor card?	Yes/No	
Birth Control method?	_____	

Gyn/Obstetrical History (women only)

Age at onset of periods _____ Frequency _____ Length _____

Number of pregnancies _____ Births _____ Miscarriages _____

History of abnormal papsmear? If yes, describe _____

Patient signature _____ **Date** _____

Provider Signature _____ **Date** _____ **Time** _____