Name: _____ **Date of Birth** _____

Current Medications	**Dose**	**# time per day**	**how long have you taken this**
1)			
2)			
3)			
4)			
5)			
6)			

Allergies	**Reaction that occurs(rash, hives, etc)**
1)	
2)	
3)	
4)	

Past Medical History

Surgeries Year	**Type of surgery: breast, gallbladder, appendix etc.**
1)	
2)	
3)	
4)	

Hospitalizations Year	**Reason: Chest Pain, Pneumonia, Diabetes, Ulcers etc.**
1)	
2)	
3)	

Other Illnesses **Examples: High Blood Pressure, Migraines**

1) _____ 2) _____

3) _____ 4) _____

Vaccines

Last Tetanus Vaccine date ? _____

Have you had Pnuemonia vaccine ? _____ When _____

Have you had a flu shot? _____ When _____

Female last appt date:

Gyn _____ Breast _____

Pelvic _____ Mamogram _____

Last menstal period _____

Days between periods _____

Male last appt date:

PSA _____

Prostate Exam _____

Social History(ck one)	**YES**	**NO**		
Smoking	◯	◯	Packs/day _____	Year started _____
Alcohol	◯	◯	Quaytity _____	day week month
Exercise	◯	◯	Type _____	Frequency _____
Recreational drugs	◯	◯	Type _____	Frequency _____
Seat Belt worn	◯	◯		
Sexual Activity	◯	◯		
Advanced Directive	◯	◯	Power of Attorney	◯ yes ◯ no

Preferred Pharmacy: _____ **Pharmacy phone** _____

Name: _____ **Date of Birth** _____

FAMILY HEALTH HISTORY

Current age if Living	Age At Death		stroke	diabetes	high blood pressure	heart disease	tuberculosis	anemia	bleeder	obesity	seizures	asthma	mental illness	cancer	other
		Father													
		Mother													
		list siblings:													

Yes	No	Check if you have any of the following and explain
		Weakness _____
		Change in Appetite _____
		Weight loss or gain _____
		Rash _____
		Anemia _____
		Headache _____
		Seizure _____
		Dizziness _____
		Visual changes _____
		Deafness _____
		Nasal Congestion _____
		Post Nasal Drip _____
		Breast Mass _____
		Asthma _____
		Shortness of Breath _____
		Pneumonia _____
		Chest pain _____
		Palpitations _____
		High blood pressure _____
		Swelling _____
		Nausea/Vomitting _____
		Diarrhea _____
		Constipation _____
		Changes in Stool _____
		Ulcers _____
		Jaundice _____
		Gallstones _____
		Pain in Urination _____
		Frequent Urination _____
		Kidney Stone _____
		Joint Pain _____
		Back Pain _____
		Diabetes _____
		Thyroid Disorder _____
		Anxiety _____
		Sleep Disturbances _____
		Menopause Age _____