Why are you seeing the doctor? _____

Other Physicians you have seen recently? _____

PAST MEDICAL HISTORY: Check if you have had the following:

☐ Arthritis	☐ Depression	☐ Hepatitis	☐ Sleep Disorder
☐ Asthma	☐ Diabetes	☐ Colitis	☐ Rheumatic Fever
☐ Anxiety	☐ Seizures	☐ Tuberculosis	☐ Venereal Disease _____
☐ Ulcers	☐ Gout	☐ Heart Trouble	☐ High Blood Pressure
☐ Other _____			

Have you recently had an immunization? ☐ No ☐ Yes Date/Type _____

Have you had a blood transfusion? ☐ No ☐ Yes Date/Reason _____

Have you been involved in a serious accident: ☐ No ☐ Yes Date/Details _____

Have you ever had a fracture? ☐ No ☐ Yes Date/Details _____

Do you drink alcohol? ☐ No ☐ Yes Type _____ How much? _____

Do you smoke? ☐ No ☐ Yes How much? _____ For how many years? _____

Do you take aspirin? ☐ No ☐ Yes Other NSAID? _____

Do you drink coffee ☐ No ☐ Yes Cups per day _____

List all the things to which you are allergic _____

List all medication you are taking or have taken within 10 days: _____

List all surgeries you have had

Date:	**Hospital**	**Purpose**

Have you ever been in a hospital for any other reason? _____

THE FOLLOWING GIVES THE DOCTOR AN IDEA OF YOUR FAMILY'S MEDICAL HISTORY:

	Age	**Medical Problems**	**Age & Cause of Death**
Mother			
Father			
Sisters			
Brothers			

HAS ANY BLOOD RELATIVE OF YOURS HAD PROBLEMS WITH THE FOLLOWING?

☐ High Blood Pressure	☐ Heart Trouble	☐ Arthritis	☐ Diabetes
☐ Thyroid Problems	☐ Tuberculosis	☐ Gout	☐ Kidney Disease
☐ Color Blindness	☐ Epilepsy	☐ Stroke	☐ Glaucoma
☐ Nervous Breakdown	☐ Hemophilia	☐ Ulcer	☐ Cancer

WOMEN ONLY

First day of your last menstrual period? _____ Last Pap Smear _____

How many times have you been pregnant_____ Last Mammogram _____

How many children have you had _____ Menopause Date _____

IF PATIENT IS A CHILD, PLEASE ANSWER THE FOLLOWING

Birth Weight _____ Full Term baby? _____ Home from Hospital with you? _____

How healthy in infancy? _____