

PLEASE PRINT

Date _____

Patient Name _____
Last First MI

Date of Birth _____ Age _____ Height _____ Weight _____

Antihistmine or Drug Allergies _____

What prescription/non prescription medicine / supplements do you take? (Additional space on back of form)

PAST MEDICAL HISTORY Have you ever had the following? (Check yes or no. Leave blank if uncertain)

- AIDS or HIV + Yes No
- Anemia Yes No
- Arthritis Yes No
- Asthma Yes No
- Back Trouble Yes No
- Bladder Infections Yes No
- Bleeding Tendency Yes No
- Bronchitis Yes No
- Cancer Yes No
- Chickenpox Yes No
- Diabetes Yes No
- Diphtheria Yes No
- Glaucoma Yes No
- Heart Disease Yes No
- Hemorrhoids Yes No
- Hepatitis Yes No
- Hernia Yes No
- High or Low BP Yes No
- Hives or Eczema Yes No
- Infectious Mono Yes No
- Kidney Disease Yes No
- Measles Yes No
- Migraines Yes No
- Mitral Valve Yes No
- Pneumonia Yes No
- Mumps Yes No
- Polio Yes No
- Rheumatic Fever Yes No
- Scarlet Fever Yes No
- Smallpox Yes No
- Stroke Yes No
- Transfusions Yes No
- Tuberculosis Yes No
- Ulcer Yes No
- Venereal Disease Yes No
- Whooping Cough Yes No
- Any other disease – Please list

THE LAST TIME YOU HAD (list year)

Cholesterol Test _____ Rectal Exam _____

Eye Exam _____ Rubella Vaccine _____

Flu Vaccine _____ Sigmoidoscopy _____

Hepatitis Vaccine _____ Stool Blood Test _____

Pneumonia Shot _____ TB Test _____

PSA Test _____ Tetanus Shot _____

SOCIAL HISTORY

Alcohol Yes No drinks/week _____

Caffeine Yes No cups/day _____

Illegal Drugs Yes No type _____

Tobacco Yes No pack/day _____ years _____

Relative	Age	Deceased	Health Problems
Father			
Mother			
Siblings			
Grandparents			

Year	Illness / Operation

FOR FEMALES ONLY

Age onset menstrual period _____ Date last menstrual period _____

Duration of periods _____ Date of last PAP Test _____

Had painful menstruation? Yes No Had irregular menstruation? Yes No

Use birth control? Yes No Type _____

YEAR OF LAST Breast Exam _____ Was it normal? Yes No

Number of pregnancies _____ Number of abortions _____

Number of live births _____ Number of miscarriages _____

FOR MALES ONLY

Any Swelling of testicles? Yes No Any problems obtaining or maintaining an erection? Yes No



PATIENT IDENTIFICATION LABEL

