Name:_____ DOB: _____

(Please Print)

Medical History: Have you ever had? Check "Y" for a yes response, "N" for a no response. Please answer all questions.

	Y	N		Y	N		Y	N
Measles			Pneumonia			Angina		
Chicken Pox			Scarlet Fever			High or Low Blood Pressure		
Bone / Joint Disease			Migraine Headache			Asthma		
Cancer			Venereal Diseases			Stroke		
Tuberculosis			Diabetes			Hernia		
Stomach Ulcers			Nervous Breakdown			Kidney Problems		
Hives / Rashes			Thyroid Problems			Back Pain		
Heart Trouble			Liver Trouble			Alcohol / Drug Problems		

Hospital Admissions: Include year you were admitted to hospital and reason.

Year	Illness or Operation	Year	Illness or Operation

Medications: List all medications that you are now taking. Include over the counter medications and herbal medications.

Name of Drug	Strength	How Often	Name of Drug	Strength	How Often
			Drug Allergies:	Other Allergies:	

Immunization: Please indicate the year of the last dose of each vaccine.

Tetanus / Diphtheria		H. Flu		Measles	
Mumps		Rubella		Hepatitis	
Polio		Flu		Pneumonia	

Menstrual History (Women Only)

Date of last period	Number of pregnancies
Age of first period	Number of lives births

Social History: Please complete all questions**.**

Smoking History: ☐ Do not smoke ☐ Quit Smoking, when?	How long have you smoked? How many packs a day?	Alcohol use: Yes/No If yes, how many drinks per week?

Family History: If any blood relative has suffered from the following – please indicate which relative.

Tuberculosis		Stroke		Migraines		Heart Disease	
Epilepsy		Diabetes		Cancer		High Blood Pressure	
Arthritis		Kidney Disease		Mental Illness			

Systems Review: Do you currently have? Check "Y" for a yes response, "N" for a no response. Please answer all questions.

	Y	N		Y	N		Y	N
Fatigue			High Blood Pressure			Rash		
Weakness			Chest Pain			Eczema / Psoriasis		
Insomnia			Irregular Heartbeat			Hives		
Weight Loss								
Weight Gain			Joint Pain / Swelling			Loss of Appetite		
			Back Pain			Trouble Swallowing		
Headaches			Varicose Veins			Nausea / Vomiting		
Blurry Vision			Swollen Ankles			Abdominal Pain		
Double Vision						Change in Bowel Movement		
Eye Pain			Fainting Spells			Painful / Bloody Stool		
Hearing Loss			Dizziness					
Ringing in Ears			Seizures			**Females**		
Earaches			Tremors			Painful Sex		
Sore Throats			Numbness			Vaginal Discharge		
Hoarseness						Breast Soreness / Discharge		
Bleeding Gums			Depression			Breast lumps		
Swollen Gums			Nervousness			Painful Urination		
			Mental Illness					
Chronic Cough						**Males**		
Coughing up Blood			Anemia			Pain / Swelling of Testicles		
Shortness of Breath			Easy Bruising			Trouble Urinating		
			Cancer			Penile Sores or Discharge		

I HEREBY CERTIFY THAT: I have carefully read and completed the foregoing information, and that my answers and explanations are true to the best of my knowledge and belief.

Signature: _____ Date: _____/_____/_____

[Type text]