Name: ______________________ D.O.B. __________ Date: __________

What brings you in today: ______________________________

Previous Medical History: (please circle)

Hypertension	Yes	No	Diabetes	Yes	No
Cancer	Yes	No	Heart Disease	Yes	No
Migraines	Yes	No	Asthma	Yes	No
COPD/Emphysema	Yes	No	Seizures	Yes	No
Stroke	Yes	No	Thyroid disease	Yes	No
Depression or anxiety	Yes	No	High Cholesterol	Yes	No

Please List additional Previous Medical Problems or further describe above:

____

____

Previous Surgeries: (include year if known)

____

____

List all Medications: (including dosages)

____

____

Medication Allergies: ______________________________

Social History: (please check)

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Tobacco: ☐ Never ☐ Previous, but quit in ______ Current packs per day______

Amount of Alcohol in a typical week: ______________

Family Medical History:

Father ______________

Mother ______________

Siblings ______________

____

Children ______________

Please List any additional Family Medical History: ______________

____

____

____

Recent Health History: (Please check any you have experienced)

☐ Fever ☐ Weight gain or loss ☐ New or severe headache ☐ Chest pain

☐ Shortness of Breath ☐ Abdominal Pain ☐ Nausea/vomiting ☐ Change in Bowels

☐ Pain with or difficulty urinating ☐ Swelling in legs

Other: ______________________________

Previous Screening: (List dates if applicable and note any abnormal results)

Women:

Pap smear ______________

Mammogram ______________

Bone Density ______________

Colon Cancer Screening ______________

Men:

Last Prostate check ______________

Last Colon Cancer screening ______________