

Date: _____ Age: _____ Date of Birth: _____

Sex: Male Female

Do you have any concerns or questions regarding your health?

Ht _____ Wt _____

BMI _____

Have you ever had or do you have any of the following health problems?

- alcohol abuse
- asthma
- bleeding tendency
- cancer: breast uterine other
- other breast disease
- depression, mood changes
- diabetes
- eating disorder
- heart murmur
- heart problem
- hepatitis, jaundice
- high cholesterol
- high blood pressure
- kidney infection
- bladder infection
- gall bladder disease
- migraines
- stroke
- thyroid disorder
- varicose veins
- tuberculosis
- seizure disorder
- ulcers

Previous Surgeries: _____
(Type) (Dates)

Previous Hospitalizations: _____
(Type) (Dates)

Other: _____

FAMILY HISTORY:

(illnesses in blood relative ie: parents, grandparents, siblings):

- alcohol abuse
- anemia
- bleeding tendency
- cancer: breast colon other
- others: _____
- diabetes
- heart disease
- high cholesterol
- high blood pressure
- mental illness, depression
- migraine headaches
- stroke
- thyroid disorder

MEDICINES:

(regularly taken medicines including vitamins, nonprescription meds., oral contraceptives)

ADVERSE DRUG REACTIONS :

(include drug allergies and any adverse reactions)

Health and Lifestyle:

Do you smoke? yes no. If yes, how much? _____ For how long? _____

Are you concerned about your own or someone else's alcohol abuse? yes no

Have you ever felt you should cut down on your drinking? yes no

Have people annoyed you by criticizing your drinking? yes no

Have you ever felt bad or guilty about your drinking? yes no

Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?
 yes no

Do you often have the feeling of being overwhelmed or depressed? yes no

Do you exercise? yes no. If yes, what kind? _____ How often? _____

Do you use a seatbelt at least 90% of the time? yes no

ID# _____ Name _____

Have you had any of the following symptoms?

(Explain below)

- fevers, night sweats, unexplained weight loss, fatigue, headaches, vision problems, hearing problems, dizziness, ringing in ears, eye or ear pain, nose bleeds, sore throat, difficulty swallowing, hoarse voice, chest pain, palpitations, swelling of extremities, shortness of breath, inability to sleep flat, persistent cough, coughing up blood, abdominal pain, change in bowel habits, blood in stool or black stool, change in size or color of mole, burning with or difficulty with urination, blood in urine, frequent urine, numbness of extremities, joint pain

Horizontal lines for notes or additional information.

Immunization Update (include year):

Tetanus, TB Skin Test, Varicella (chicken pox) Vaccine, Rubella, Flu Shot, Pneumovax (pneumonia) Vaccine

Immunizations Given:

SEXUAL HISTORY:

Do you examine your breasts/testicles monthly? Have you ever been sexually active? Are you having sexual relations with one partner multiple partners? Are your sexual preferences men women both? Do you and your partner use contraceptive and/or protective methods? Have you ever had a Sexually Transmitted Disease (ie: HPV, Herpes, Chlamydia, Gonorrhea, or other)?

FOR WOMEN ONLY - GYNECOLOGICAL HISTORY:

Do you have a period every month? Menstrual cramps Date of last PAP smear: Result: Have you ever had an abnormal PAP smear? Number of pregnancies: Number of abortions or miscarriages: Are you presently trying to become pregnant or will be trying soon?

Have you ever had any of the following?

- abnormal bleeding, missed periods, bladder infections, leaking of urine, night sweats, hot flashes, mood changes, vaginal dryness, insomnia, been prescribed Estrogen

Have you ever had a mammogram? If yes, date of most recent and result:

Labs Ordered:

ID# Name