Patient Name________________________________ **Date:**___________________

DOB:_________________ **Occupation** ____________________________

Have you ever had any of the following?

	Yes	No
Diabetes		
High Cholesterol		
High Blood Pressure		
Heart trouble		
Stroke		
Kidney or Urinary disorder		
Bowel or GI Disorder		
Bleeding or blood disorder		
Asthma or Emphysema		
Cancer		
Glaucoma or Eye problems		
Neurologic disorder		
Mental Illness (ADD,Anxiety, ect..)		
Thyroid problem		
Arthritis		
Sexually Transmitted Disease		
Chicken Pox		
Seasonal Allergies		
Hepatitis or Yellow Jaundice		
Blood Transfusion		
Infectious Disease		

Do you smoke or use oral tobacco?

Yes No

How much?_________________

How long? _________________

Quit: _____________________

Do you drink alcohol?

Yes No

How much? _________________

How often?_________________

Have you ever experimented with drugs?

Yes No

Drug Allergies? _____________________

Women Only

Are you Pregnant? Yes No

Last menstrual cycle _____________

Number of Pregnancies _________

Last mammogram ______________

Last Pap smear _______________

Last Colonoscopy _______________

Normal Abnormal

Do your parents, brothers or sisters have any of the following?

	Yes	No
Heart problems		
Cancer		
High Cholesterol		
Diabetes		

Other medical problems? ______________

Surgeries or Hospitalizations:	Year

Current Medications and Dosage:

Reviewed by:_______________