

Name \_\_\_\_\_ SS# \_\_\_\_\_ Date \_\_\_\_\_  
 Address \_\_\_\_\_ Occupation \_\_\_\_\_  
 Phone (home) \_\_\_\_\_ (work) \_\_\_\_\_ Date of birth \_\_\_\_\_ Age \_\_\_\_\_

**DRUG ALLERGIES**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**CURRENT MEDS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**FAMILY HISTORY**

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Self
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**HOSPITALIZATION OR SURGERY**

Reason	Date	Reason	Date

**MEDICAL HISTORY**

- |                                                            |                                                             |                                                |
|------------------------------------------------------------|-------------------------------------------------------------|------------------------------------------------|
| <input type="checkbox"/> Headache _____                    | <input type="checkbox"/> Gallbladder disease _____          | <input type="checkbox"/> Depression _____      |
| <input type="checkbox"/> Shortness of breath _____         | <input type="checkbox"/> Prostate Problems _____            | <input type="checkbox"/> Gout _____            |
| <input type="checkbox"/> Heart palpitations _____          | <input type="checkbox"/> Bowel irregularity _____           | <input type="checkbox"/> Scarlet fever _____   |
| <input type="checkbox"/> Heart murmur _____                | <input type="checkbox"/> Incontinence _____                 | <input type="checkbox"/> Chronic rashes _____  |
| <input type="checkbox"/> Chest pain _____                  | <input type="checkbox"/> Overactive bladder _____           | <input type="checkbox"/> Rheumatic fever _____ |
| <input type="checkbox"/> Dizziness/Fainting _____          | <input type="checkbox"/> Frequent Urination _____           | <input type="checkbox"/> Mumps _____           |
| <input type="checkbox"/> Peripheral vascular disease _____ | <input type="checkbox"/> Sexual/menstrual dysfunction _____ | <input type="checkbox"/> Measles _____         |
| <input type="checkbox"/> Allergies/Hay fever _____         | <input type="checkbox"/> Venereal disease _____             | <input type="checkbox"/> Rubella _____         |
| <input type="checkbox"/> Asthma _____                      | <input type="checkbox"/> Frequent infections _____          | <input type="checkbox"/> Polio _____           |
| <input type="checkbox"/> Bronchitis _____                  | <input type="checkbox"/> Hepatitis _____                    | <input type="checkbox"/> Diphtheria _____      |
| <input type="checkbox"/> Pneumonia _____                   | <input type="checkbox"/> Anemia _____                       | <input type="checkbox"/> Tetanus _____         |
| <input type="checkbox"/> Ulcer _____                       | <input type="checkbox"/> Arthritis _____                    |                                                |
| <input type="checkbox"/> GI disorder _____                 | <input type="checkbox"/> Osteoporosis _____                 |                                                |
| <input type="checkbox"/> Lactose intolerance _____         | <input type="checkbox"/> Nervousness _____                  |                                                |

**HABITS**

- |                                                                                                       |                                                                           |                                                                                                                                                                                               |
|-------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Smoke: Packs daily _____<br>How long? _____<br>Interested in stopping? _____ | <input type="checkbox"/> Coffee: Cups daily _____<br>Other caffeine _____ | <input type="checkbox"/> Sleep: Difficulty falling asleep _____<br>Continuity disturbances _____<br>Snoring _____<br>Early morning awakening _____<br>Daytime drowsiness _____<br>Other _____ |
| <input type="checkbox"/> Exercise routine: _____<br>_____                                             | <input type="checkbox"/> Alcohol: Type _____<br>Amount _____              |                                                                                                                                                                                               |
|                                                                                                       | <input type="checkbox"/> Diet: Salt intake _____<br>Fat intake _____      |                                                                                                                                                                                               |