Name: ______________________________ Date: ________________

Chief Complaint: ____

Past Medical Problems: Circle Yes/No. If "Yes" please state when you were diagnosed and explanation of your condition.

Hypertension: Yes/No____

Cancer: Yes/ No ____

Stroke: Yes/ No ____

Thyroid Problems: Yes/ No ____

Asthma: Yes/ No ____

Heart condition or Heart disease: Yes/ No ____________________________

HIV: Yes/ No ____

Hypercholestrol: Yes/No ____

Diabetes: Yes/ No ____

Arthritis: Yes/No ____

Arthoplasty/Joint Replacement: Yes/ No ______________________________

Seizures: Yes/No ____

Pacemaker/Difibrillator: Yes/No ____________________________________

Allergies (medication or environmental): Yes/No __________________________

Please list any addition medical conditions: ____________________________

List of Medications: & the Dosage:

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

History of surgeries (please list approximate date and all procedures):

Date: ____________ **Procedure:** ____________________________________
Date: ____________ **Procedure:** ____________________________________
Date: ____________ **Procedure:** ____________________________________
Date: ____________ **Procedure:** ____________________________________

History of Hospitalizations: (please list approximate date and reason for hospitalization):

Date: ____________ **Procedure:** ____________________________________
Date: ____________ **Procedure:** ____________________________________
Date: ____________ **Procedure:** ____________________________________
Date: ____________ **Procedure:** ____________________________________

Smoking status: Current smoker ____Former smoker _____Non-smoker____

Alcohol Status: Yes/No How often do you drink? ______________________

Have you used any drugs other than those for medical reasons in the past 12 months? Yes/No

Marital Status: Single ______ Married ______ Widowed _____ Divorced ____

Number of children: _________

Living with:
Alone ______ Family member ______ partial assistance ______ Spouse ______
Type of Housing: Single ____ 2 story ____Apartment _____Group Home ____

Patient Signature ______________________________ Date _________

<u>Family History:</u> Please circle one

1. Is your Father Alive or Decease

2. Is your Mother Alive or Decease

Did or do your parents have any medical history? If so please indicate who and list their medical history;

1.______________________________ 2.______________________________

3.______________________________ 4______________________________

5.______________________________ 6.______________________________

Do you have any brothers or sisters? If so how many brothers _________ and how many sisters_______. Do they have any medical history? Yes or No

If yes please list their medical history…

1.______________________________ 2.______________________________

3.______________________________ 4______________________________

5.______________________________ 6.______________________________

Do you have any kids? If so how many boys_________ and how many girls_________ Do they have any medical history? Yes or No

If yes please list their medical history…

1.______________________________ 2.______________________________

3.______________________________ 4______________________________

5.______________________________ 6.______________________________