

Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_  
Last First Middle Initial

What is the reason for your office visit today? Upper Respiratory Infection Hypertension Diabetes Chest Pain Abdomen Pain  
High Cholesterol Migraines Urinary Tract Infection Other:

**MEDICATIONS** (List all meds, strength & frequency, include non-prescriptions & herbs/supplements as well)

**PAST MEDICAL HISTORY & SURGERIES** (List ALL diseases, conditions, hospitalizations & surgeries with dates)

**ALLERGIES** (List all medications, foods or agents & the reaction) No Allergies

**FAMILY HISTORY:**

Indicate if any immediate family members have the following conditions or diseases and who they are:

Mother (M) **Alive / Deceased** Father (F) **Alive / Deceased** Paternal Grandmother (PGM) **Alive / Deceased**  
Paternal Grandfather (PGF) **Alive / Deceased** Maternal Grandmother (MGM) **Alive / Deceased**  
Maternal Grandfather (MGF) **Alive / Deceased** Brother (B) **Alive / Deceased** Sister (S) **Alive / Deceased**

- Alzheimer's disease  Diabetes  Osteoporosis  Other cancers \_\_\_\_\_
- Anemia  Hypertension  Prostate Cancer  Others \_\_\_\_\_
- Bleeding Disorder  Colon Cancer  Thyroid Disease \_\_\_\_\_
- Breast Cancer  Melanoma  Heart attack / coronary artery disease

**SOCIAL HISTORY:**

Tobacco:  NON-SMOKER  Currently use  Past use  
Second hand smoke exposure  Yes  No  Quit Date: \_\_\_\_\_  
How much? \_\_\_\_\_ pack/day Duration: \_\_\_\_\_ mth /years  
How much? \_\_\_\_\_ pack/day Duration: \_\_\_\_\_ mth /years

Alcohol:  Don't Drink  Currently use  Past use  
 Quit Date: \_\_\_\_\_  
How much? \_\_\_\_\_ day/wk Duration: \_\_\_\_\_ mth /years  
How much? \_\_\_\_\_ day/wk Duration: \_\_\_\_\_ mth /years

Exercise:  Yes  No Type: \_\_\_\_\_ How long? \_\_\_\_\_ Hrs. Frequency \_\_\_\_\_ a week  
Diet: \_\_\_\_\_ Occupation: \_\_\_\_\_  
Any history of sexually transmitted disease?  YES  NO When? \_\_\_\_\_ Was it treated?  YES  NO  
Any recreational drug use?  YES  NO If yes indicate: \_\_\_\_\_

**IMMUNIZATION HISTORY:** When was your most recent?

Tetanus Shot (Td) \_\_\_\_\_ Hepatitis B: \_\_\_\_\_ Pneumococcal Vaccine: \_\_\_\_\_ Flu Shot \_\_\_\_\_

**PAST PREVENTIVE CARE:** When was your most recent?

Annual Physical Exam: \_\_\_\_\_ Well Woman Exam: \_\_\_\_\_ Eye Exam: \_\_\_\_\_ EKG: \_\_\_\_\_  
Mammogram: \_\_\_\_\_ Normal / Abnormal Bone Density Test: \_\_\_\_\_ Normal / Abnormal  
Colonoscopy / Sigmoidoscopy: \_\_\_\_\_ Normal / Abnormal PSA/Prostate Screen: \_\_\_\_\_ Normal / Abnormal

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_  
01/10/2017