

PATIENT INFORMATION

Name	Birth Date	Age	Religious Affiliation
Occupation	Reason for Visit _____		
Race	Ethnicity	Language	

HOUSEHOLD STATUS (spouse, children, other family members living in your home?)

PERSONAL MEDICAL HISTORY (Please check past or present history of the following conditions:)

Past	Present	Condition	Past	Present	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap Smear or Mammogram	<input type="checkbox"/>	<input type="checkbox"/>	Hernia
<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol/Drug Problems	<input type="checkbox"/>	<input type="checkbox"/>	High Cholesterol
<input type="checkbox"/>	<input type="checkbox"/>	Anemia/Bleeding Problem	<input type="checkbox"/>	<input type="checkbox"/>	Infertility (difficulty getting pregnant)
<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/Gout	<input type="checkbox"/>	<input type="checkbox"/>	Kidney/Bladder Problems
<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease/Jaundice/Hepatitis
<input type="checkbox"/>	<input type="checkbox"/>	Cancer (Type: _____)	<input type="checkbox"/>	<input type="checkbox"/>	Mental Trouble/Depression/Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts/Vision Loss/Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever
<input type="checkbox"/>	<input type="checkbox"/>	Circulation Problems	<input type="checkbox"/>	<input type="checkbox"/>	Seizures/Fits/Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	COPD/Emphysema/Asthma/Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	Serious Injury/Accident
<input type="checkbox"/>	<input type="checkbox"/>	Diabetes (sugar)	<input type="checkbox"/>	<input type="checkbox"/>	Sickle Cell Anemia
<input type="checkbox"/>	<input type="checkbox"/>	Eating Disorder (anorexia/bulimia)	<input type="checkbox"/>	<input type="checkbox"/>	Skin Disorders
<input type="checkbox"/>	<input type="checkbox"/>	Genital Herpes/Infections/Warts/GC	<input type="checkbox"/>	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever/Pollen Allergy	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problem
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Transfusion (year: _____)
<input type="checkbox"/>	<input type="checkbox"/>	Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis (TB)
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack/Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	<input type="checkbox"/>	Other (specify: _____)
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids/Polyps (Colon)			

PAST SURGERIES, SERIOUS INJURIES, OR PREGNANCIES

PERSONAL HABITS:

Past or present use of tobacco products? Yes No
(If so, please list what kind, how much, how long, and date last used.)

Past or present use of alcohol? Yes No
(If so, please list how much and how often.)

Past or present use of street drugs? Yes No
(If so, please list what kind and how often.)

Do you have an advanced directive? Yes No

FAMILY MEDICAL HISTORY: (Cancer, heart trouble, high blood pressure, diabetes, TB, blood problems, any other problems in parent, grandparents, siblings, and/or children)

ALLERGIES:

MEDICATIONS PRESENTLY BEING USED: (prescriptions, over-the-counter, and/or alternative)

IMMUNIZATIONS: Last Tetanus? _____ Pneumovax? _____
WOMEN ONLY: Last PAP Smear? _____ Last Mammogram? _____