

Patient Information

Name: _____ Date of birth: _____

Allergies

Is patient adopted? YES NO _____

Interpreter needed? YES NO _____

Medications

Please list all of the medications you are taking, including any vitamins, herbal medicines, and "over-the-counter" medications.

NAME OF MEDICATION	DOSE	FREQUENCY

Medical History

If your answer is "YES" to a question, please explain on the line following the question.

- None? YES NO _____
- Thyroid Problems? YES NO _____
- Seizures?..... YES NO _____
- Stroke? YES NO _____
- Asthma? YES NO _____
- C.O.P.D.?..... YES NO _____
- Sleep Apnea? YES NO _____
- Coronary Artery Disease? YES NO _____
- Congestive Heart Failure?..... YES NO _____
- Chest Pain? YES NO _____
- High Blood Pressure?..... YES NO _____
- Elevated Cholesterol? YES NO _____
- Heart Attack? YES NO _____
- Implantable Devices? YES NO _____
- Cardiac Arrhythmia?..... YES NO _____
- Rheumatic Fever? YES NO _____
- Diabetes? YES NO _____
- Liver Problems?..... YES NO _____
- Stomach Problems? YES NO _____

(continued...)

Medical History *(continued)*

- Irritable Bowel Syndrome? YES NO _____
- Reflux (G.E.R.D)?..... YES NO _____
- Kidney Problems? YES NO _____
- Incontinence of Urine?..... YES NO _____
- Genitourinary Problems?..... YES NO _____
- Osteoporosis? YES NO _____
- Back or Neck Problems?..... YES NO _____
- Arthritis? YES NO _____
- Skin Problems? YES NO _____
- Anemia? YES NO _____
- Blood Disorder?..... YES NO _____
- M.R.S.A. / V.R.E.? YES NO _____
- Tuberculosis? YES NO _____
- C-difficile?..... YES NO _____
- Hepatitis?..... YES NO _____
- HIV or AIDS? YES NO _____
- STDs?..... YES NO _____
- Depression? YES NO _____
- Anxiety?..... YES NO _____
- Eating Disorder?..... YES NO _____
- Menstrual Problems?..... YES NO _____
- Abnormal Pap Smear? YES NO _____
- Cancer? YES NO _____
- Other Medical Problems? YES NO _____
- Hospitalizations? YES NO _____
- Are Immunizations on Schedule?..... YES NO _____
- Previous reaction to immunizations?..... YES NO _____

Surgical History

If your answer is "YES" to a question, please explain on the line following the question.

- None?..... YES NO _____
- Appendectomy?..... YES NO _____
- Breast Biopsy? YES NO _____
- Cholecystectomy? YES NO _____
- Coronary Artery Bypass?..... YES NO _____
- Hernia? YES NO _____
- Hip Replacement?..... YES NO _____
- Hysterectomy?..... YES NO _____
- Knee Replacement? YES NO _____
- Other Surgical Procedures? YES NO _____

(continued...)

Family History

Please indicate which of your relatives have had any of the following conditions.

	Parent		Parent		Maternal		Maternal		Paternal		Paternal		Siblings	
	Mother	Age of Onset	Father	Age of Onset	Grand-mother	Age of Onset	Grand-father	Age of Onset	Grand-mother	Age of Onset	Grand-father	Age of Onset	Sister	Brother
Unknown	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Aneurysms	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Bleeding Tendencies	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Breast Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Colo-Rectal Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Ovarian Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Pancreatic Cancer	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Other Cancers	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Alcohol Dependence	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Drug Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart Problems	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Hypertension	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Mental Illness	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Other Health Problems	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
None	<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N		<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N

Is your father deceased? YES NO _____

Is your mother deceased? YES NO _____

Social History

Marital Status: Married Single Divorced Widowed Other _____

Occupation: _____

Highest level of education: College High School G.E.D. Other _____

Number of living children: _____

Do you have special religious or cultural needs? YES NO _____

Health Risk Profile

If your answer is "YES" to a question, please explain on the line following the question.

Allergic to latex? YES NO _____

Reaction to a medical procedure? YES NO _____

Reaction to a dental procedure? YES NO _____

Allergic to bananas? YES NO _____

Allergic to kiwis? YES NO _____

Allergic to avocados? YES NO _____

Allergic to chestnuts? YES NO _____

Tobacco use? YES NO _____

Prior tobacco use? YES NO _____

Exposure to secondhand smoke? YES NO _____

Other tobacco use? YES NO _____

Alcohol use? YES NO _____

Recreational drug use? YES NO _____

Caffeine use? YES NO _____

(continued...)

Do you feel safe at home?..... YES NO _____

Do you want to discuss abuse?..... YES NO _____

Is someone threatening you? YES NO _____

Health Risk Prevention

Exercise regularly?..... YES NO _____

Maintain a healthy weight?..... YES NO _____

Helmet use? YES NO _____

Seatbelt use?..... YES NO _____

Smoke detectors in your home?..... YES NO _____

Carbon monoxide detectors in your home?..... YES NO _____

Health Risk Hazard Exposure

Lead exposure?..... YES NO _____

Exposure to other chemicals? YES NO _____

Type of Contraception

Sexually active?..... YES NO _____

None?..... YES NO _____

Birth Control Pill?..... YES NO _____

Birth Control Patch? YES NO _____

Birth Control Ring? YES NO _____

Condoms? YES NO _____

Diaphragm/cap/shield?..... YES NO _____

Depo Provera? YES NO _____

Implant?..... YES NO _____

I.U.D? YES NO _____

Sponge/Spermicide? YES NO _____

Tubal Sterilization? YES NO _____

Vasectomy? YES NO _____

Other?..... YES NO _____

Symptoms- *Please circle any of the following symptoms that you have now or have had recently.*

Fever	Unexplained Weight Loss	Chills
Changes in Vision	Difficulty Swallowing	Problems with Hearing
Chest Pain	Racing Heart	Palpitations
Cough	Wheezing	Shortness of Breath
Stomach Pains	Blood in Stool	Constipation
Blood in Urine	Burning During Urination	Difficulty Starting/Stopping Stream
Joint Pain	Black Stools	Foot Swelling
Depression	Anxiety	Panic Attacks
Excessive Thirst	Frequent Urination	Swelling in the Neck
Swollen Glands	Easy Bleeding	Poor Healing
Frequent Headaches	Loss of Consciousness	Numbness in Arms/Legs
Worrisome or Changing Skin Lesions	Hair loss	Skin Rashes