

PRESENT MEDICAL HISTORY

Please list any chronic medical problems: _____

Current medications:	Medication Name	Dose	How many times daily or used as needed?
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____
	_____	_____	_____

Please list any drug allergies you have and their reaction: _____

PAST SURGICAL HISTORY -- Have you ever been operated on for: (please indicate date)

- | | |
|-------------|---------------|
| Tonsils | Ovaries |
| Gallbladder | Uterus |
| Appendix | Prostate |
| Thyroid | Hernia Repair |
| Hemorrhoids | Other _____ |

Have you ever had a blood transfusion? _____ If yes, date given _____

VACCINATION HISTORY -- Please fill in the last date that each vaccination was given.

- | | |
|-----------------|----------------|
| Pneumovax _____ | Flu shot _____ |
| Tetanus _____ | Other _____ |

PREVENTIVE MEDICINE -- Please fill in the last date that each test was performed.

- | | |
|---------------------|-------------------------|
| Pap Smear _____ | Prostate Exam _____ |
| Mammogram _____ | Hemoccult Testing _____ |
| Flexible _____ | Treadmill _____ |
| Sigmoidoscopy _____ | |

HABITS

Do you smoke? _____ If so, how much? _____

Do you drink alcohol? _____ Do you exercise regularly? _____

Is your weight stable? _____ Weight one year ago _____ Height _____

FAMILY HISTORY -- Who (if anyone) in your family has had: (Please indicate mother, father, uncle, etc.)

- | | |
|------------------|----------------|
| Hypertension | Ovarian Cancer |
| Diabetes | Breast Cancer |
| High Cholesterol | Colon Cancer |
| Heart Attack | Alzheimer's |
| Stroke | Other: _____ |

WOMEN ONLY

Age of onset of menstruation _____ Length of cycle (start to start) _____

Date of last period _____ Number of pregnancies _____

Number of full term births _____ Number of miscarriages _____

Current Complaints: