

Today's Date: _____

Referred by: _____

Name _____ Age _____ SS# _____
Birthdate _____ Home Tel: (____) _____ Work Tel: (____) _____
Address _____ City _____ State _____ Zip _____

SOCIAL HISTORY

Occupation _____ Marital Status _____

HABITS

Smoke _____ Packs Daily _____ How Long _____ When Stopped _____
Exercise Routine _____
Coffee _____ Cups Daily _____ Other Caffeines _____
Alcohol _____

DRUG ALLERGIES (List all)

Please list all CURRENT MEDICATIONS

| Name | Dosage / # times daily |
|-------|------------------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

FAMILY HISTORY (including parents, grandparents, siblings, etc.)

| Mother : Alive / Deceased | Father: Alive / Deceased | Adopted: Yes / No |
|---------------------------|--------------------------|-------------------|
| Asthma _____ | Diabetes _____ | |
| Heart Disease _____ | Epilepsy _____ | |
| Hypertension _____ | Ulcer Disease _____ | |
| Stroke _____ | Kidney Disease _____ | |
| Cancer _____ | Arthritis _____ | |
| Colon Cancer/Polyps _____ | Anemia _____ | |

SURGERY

| Reason | Date |
|--------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

OTHER HOSPITALIZATIONS

| Reason | Date |
|--------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

PAST MEDICAL HISTORY

Do you have or have you had any of the following? (Please check all that apply)

| | | |
|--------------------------------|------------------------------------|------------------------------------|
| Alcoholism _____ | Dizziness/Fainting _____ | Liver Disease _____ |
| Allergies/Hay Fever _____ | Emphysema _____ | Menstruation Dysfunction _____ |
| Anemia _____ | Endocrine Disease _____ | Other Gynecological Disorder _____ |
| Anxiety _____ | Epilepsy _____ | Renal Disease _____ |
| Arrhythmia _____ | Gallbladder _____ | Rheumatic Fever _____ |
| Arthritis _____ | GI Disorder _____ | Scarlet Fever _____ |
| Artificial Heart Valve _____ | Glaucoma _____ | Sexual Dysfunction _____ |
| Asthma _____ | Gout _____ | Shortness of Breath _____ |
| Blood Transfusions _____ | Heart Attack _____ | Stroke _____ |
| Chest Pain/Angina _____ | Heart Murmur _____ | Ulcer _____ |
| Colon Polyps _____ | Heart Palpitations _____ | Urological Disorder _____ |
| Congenital Heart Disease _____ | Hepatitis: A _____ B _____ C _____ | Vascular Heart Disease _____ |
| Congestive Heart Failure _____ | Hyperlipidemis _____ | Venereal Disease _____ |
| Diabetes _____ | Hypertension _____ | |