Name: _____ DOB:_____ Today's Date:_____

PAST MEDICAL HISTORY

☐ Alcohol/Substance Abuse issues	☐ Ear Problem/Hearing Problem	☐ Osteoporosis
☐ Allergies/Immune Problem	☐ Eye or Vision Problem	☐ Arthritis
☐ Anemia	☐ Fibromyalgia	☐ Rheumatologic Problem
☐ Anxiety/Depression/Stress	☐ Gastrointestinal Problem	☐ Sexually Transmitted Disease
☐ Asthma	☐ Headaches/Migraines	☐ Seizures/Epilepsy
☐ Blood Clots	☐ Liver Disease	☐ Stroke
☐ Cancer_____	☐ High Blood Pressure	☐Urinary/Kidney Problem
☐ COPD/Emphysema	☐ High Cholesterol	☐ Other Serious Illness:_____
☐ Colon/Bowel Problems	☐ Insomnia/Sleep Apnea	_____
☐ Dermatology/Skin Problems	☐ Mental Health Problem	_____
☐ Diabetes	☐ Neurologic Problem	☐ Hospitalizations:_____
☐ Dizziness/Vertigo	☐ Orthopedic Problem	_____

PAST SURGICAL HISTORY

Last Screening Colonoscopy: _____

☐ Angioplasty/Stent Placement	☐ Heart Surgery-other	☐ Prostate Surgery
☐ Appendectomy	☐ Hernia Repair	☐ Thyroid Surgery
☐ Bladder Surgery	☐ Hysterectomy-☐ abdominal	☐ Tonsillectomy
☐ Breast Surgery	☐ vaginal	☐ Other Surgeries:
☐ Cancer Surgery	☐ Joint Surgery_____	_____
☐ C-Section	_____	_____
☐ Coronary Artery Bypass Surgery	☐ Joint Replacement Surgery	_____
☐ Gallbladder Surgery	_____	_____

GYN HISTORY (females only)

Age at first child:_____	When was your last mammogram? _____
Age at first menstrual period: _____	
Are your periods regular? ☐ Yes ☐ No	If you have gone through menopause,
How often do you get your period? _____	how old were you? _____
When was your last period? _____	Have you had a hysterectomy? ☐ Yes ☐ No
If you are using birth control, what type? _____	What was the date of the hysterectomy? _____
When was your last pap smear?_____	Have you ever had a bone density? ☐ Yes ☐ No
Have you ever had an abnormal pap? ☐ Yes ☐ No When:_____	When was your last bone density? _____

SOCIAL HISTORY

Marital Status: ☐Single ☐Married ☐Life Partner ☐Divorced ☐Widowed	How often do you exercise? ☐< 1x/wk ☐2-3x/wk ☐4-5x/week ☐6-7xwk What time of exercise do you do?_____
Number of Children: _____	Do you drink alcohol: ☐Yes ☐No
Occupation: _____	How often? ☐rarely ☐occasionally ☐frequently
Education: ☐High School ☐ Some College ☐ 4-year College	How many drinks/week? _____
☐ Graduate School/Professional Degree	Do you use recreational drugs? ☐Yes ☐No
Do you smoke? ☐ Yes ☐ No How much? _____	Do you have a smoke alarm at home? ☐Yes ☐No
How many years have you/did you smoked? _____	Do you always use seat belts? ☐Yes ☐No
Do you chew tobacco? ☐Yes ☐No How much? _____	Do you use sunscreen regularly? ☐Yes ☐No

FAMILY HISTORY

Illness	Family Member	Age at Onset/Death	Illness	Family Member	Age at Onset/Death
☐ Alcohol/Substance Abuse			☐ COPD/Emphysema		
☐ Alzheimer's Disease			☐ Crohn's/Ulcerative Colitis		
☐ Anemia			☐ Diabetes		
☐ Asthma			☐ Gastrointestinal Problem		
☐ Arthritis			☐ Heart Attack (MI)		
☐ Anxiety/Depression			☐ High Blood Pressure		
☐ Bipolar Disorder			☐ High Cholesterol		
☐ Blood Clots			☐ Immune Problem		
☐ Cancer-Breast			☐ Kidney Disease		
☐ Cancer-Colon			☐ Liver Disease		
☐ Cancer-Lung			☐ Circulation Problem		
☐ Cancer-Ovarian			☐ Stroke		
☐ Cancer-Prostate			☐ Thyroid Problem		
☐ Cancer-Other_____			☐ Other:_____		

IMMUNIZATIONS

Vaccine	Date Received	Vaccine	Date Received	Vaccine	Date Received
Hepatitis A		**MMR**		**Other:**	
Hepatitis B		**Pneumonia**			
Influenza		**TDaP/Tetanus**			
Meningitis		**Shingles**			