

Name: _____ DOB: _____

Reason for today's visit: _____

Current List of Medications

List all medication you are currently taking. Please include non-prescription medications, such as aspirin, Tylenol, Vitamins and herbal supplements.

Name	Dosage/Strength	Reason

Past medical History

Check all that apply

<input type="checkbox"/> Alcohol Abuse	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Lumbar Stenosis
<input type="checkbox"/> Allergic Rhinitis	<input type="checkbox"/> Diabetes (Insulin Depend)	<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Alzheimers	<input type="checkbox"/> Drug Abuse	<input type="checkbox"/> Osteopenia
<input type="checkbox"/> Anemia	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Anxiety	<input type="checkbox"/> GERD (Heartburn)	<input type="checkbox"/> Palpitations
<input type="checkbox"/> Asthma	<input type="checkbox"/> Gout	<input type="checkbox"/> Peptic Ulcer Disease
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> PVD (Vascular Disease)
<input type="checkbox"/> BPH (Enlarged Prostate)	<input type="checkbox"/> HIV/AIDS	<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Bronchitis-Chronic	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> RLS(Restless Leg Syndrome)
<input type="checkbox"/> Cancer	<input type="checkbox"/> Hyperlipidemia (High Chol)	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Cardiomyopathy	<input type="checkbox"/> Hypertension (High Blood Pressure)	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Hyperthyroidism	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> COPD (Lung Disease)	<input type="checkbox"/> Hypothyroidism	<input type="checkbox"/> Other (Please specify)
<input type="checkbox"/> CVA (Stroke)	<input type="checkbox"/> Irritable Bowel Disease	
<input type="checkbox"/> Dementia	<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Depression	<input type="checkbox"/> Low Back Pain	

Surgery History

Check all that apply and year (if known)

<input type="checkbox"/> Amputation	Year:	<input type="checkbox"/> Hip Replacement	Year:
<input type="checkbox"/> Appendectomy	Year:	<input type="checkbox"/> Hysterectomy	Year:
<input type="checkbox"/> Arthroscopy	Year:	<input type="checkbox"/> Knee Replacement	Year:
<input type="checkbox"/> Breast Lumpectomy	Year:	<input type="checkbox"/> Lap Band	Year:
<input type="checkbox"/> Bypass in Leg	Year:	<input type="checkbox"/> Ovary Removal	Year:
<input type="checkbox"/> Cardiac Bypass	Year:	<input type="checkbox"/> Pacemaker	Year:
<input type="checkbox"/> Cardiac Cath	Year:	<input type="checkbox"/> Prostate Surgery	Year:
<input type="checkbox"/> Cataracts	Year:	<input type="checkbox"/> Stent-Heart	Year:
<input type="checkbox"/> Colon Resection	Year:	<input type="checkbox"/> Stent-Kidney	Year:
<input type="checkbox"/> Colonoscopy	Year:	<input type="checkbox"/> Stent-Leg	Year:
<input type="checkbox"/> Cystoscopy	Year:	<input type="checkbox"/> Tonsils	Year:
<input type="checkbox"/> Endoscopy	Year:	<input type="checkbox"/> Tubes in Ears	Year:
<input type="checkbox"/> Gall Bladder Removal	Year:	<input type="checkbox"/> Vasectomy	Year:
<input type="checkbox"/> Gastric Bypass	Year:	<input type="checkbox"/> Other (Please specify)	Year:
<input type="checkbox"/> Hernia Repair	Year:	<input type="checkbox"/>	

Family Medical History

Has any family member/relative had the following?

Illness/Type	Family Member/Relative
<input type="checkbox"/> Cancer: Breast	
<input type="checkbox"/> Cancer: Colorectal	
<input type="checkbox"/> Cancer: Ovarian	
<input type="checkbox"/> Cancer: Prostate	
<input type="checkbox"/> Cancer: Other	
<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Heart Disease	
<input type="checkbox"/> Diabetes	
<input type="checkbox"/> Stroke	
<input type="checkbox"/> Depression	
<input type="checkbox"/> Anxiety	
<input type="checkbox"/> Glaucoma	
<input type="checkbox"/> Alcohol Abuse	
<input type="checkbox"/> Drug Abuse	
<input type="checkbox"/> Thyroid Disease	
<input type="checkbox"/> Rheumatoid Arthritis	
<input type="checkbox"/> Other	
<input type="checkbox"/> Other	

Allergies

List all known allergies + reason

Allergy	Reaction

Social History

Tobacco Use: Smoker Smokeless Non-Smoker

Have you ever used tobacco products? () No () Yes

What kind: _____ How much: _____ How many years: _____

Former Smoker-How long ago did you quit? _____

Other tobacco use (Chew, Snuff, Pipe)? _____

Alcohol and Drug Use: () None

Did you have a drink containing alcohol in the past year? () Yes () No

How often did you have an alcoholic drink? *Never Monthly or less 2-4/mo 2-3/wk 4 or more/wk*

What kind: _____ How much: _____ How many years: _____

Do you use drugs for reason that are not medical? () No () Yes If yes, please list _____