MEDICAL HISTORY Name_____ Age ____ Birthdate____ _____ Home Phone _____ _____ Work Phone _____ Occupation _____ Emergency Contact _____ Phone _____ Wid ☐ Married Widowed Divorced ☐ Separated Single If married, spouse's name Children's names and ages Allergies to Medications, X-Ray Dyes, or Other Substances \quad \quad No \quad \quad \text{Yes} (If ves. please list name of medicine and type of reaction) **Past Medical History and Review of Systems** Please check off if you have had any problems with or are presently experiencing any of the following: High Blood Pressure Bronchitis Diabetes Pneumonia ☐ Change in bowel habits ☐ Arthritis Unexplained Low back problems weight gain/loss Cancer Persistent cough Skin diseases Heart Disease □ т.в. Hemorrhoids Blood disorders ☐ Chest pain/chest Hay fever Gall Bladder disease ☐ Venereal diseases tightness Abdominal discomfort Colitis Anxietv Shortness of breath ☐ Indigestion Hepatitis or jaundice Depression ☐ Nausea Swollen ankles Thyroid disease ☐ Anemia Palpitations ☐ Vomiting Head or neck radiation Alcohol abuse Lightheadedness Constipation Headache Drug abuse Frequent urination ☐ Diarrhea ☐ Kidney disease Gout Rheumatic fever Blood in stool Impotence or ☐ Asthma Ulcers ☐ Difficulty urinating **Erectile Dysfunction** ☐ Other

This information is for use by your physician as part of your confidential medical record.

| Age when diagnosed Age whe | Hepatitis B? No Yes When? Fluing Other? No Yes When? Tetal When was your last: Pap Smear? Breast Exam? Cholesterol check? Family History Has any member of your family (including parents Illness White Cancer (describe type) Hypertensions (high blood pressure) Heart Disease Diabetes Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases | immunization? |
|--|---|--|
| Inspiral properties Preumovax immunization? No Yes When? Preumovax immunization? Preumovax immunization? No Yes When? Preumovax immunization? Preumovax immunization? No Yes When? Preumovax immunization? Preumovax immunization? Preumovax immunization? No Yes When? Preumovax immunization? Preumovax immunization? Preumovax immunization? Preumovax immunization? Preumovax immunization? No Preumovax immunization? Preumovax immunization** | Immunization history—have you had: Hepatitis B? Other? No Yes When? Teta When was your last: Pap Smear? Mammogram? Cholesterol check? Family History Has any member of your family (including parents lllness Cancer (describe type) Hypertensions (high blood pressure) Heart Disease Diabetes Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases | immunization? |
| Prevention Pre | Immunization history—have you had: Hepatitis B? No Yes When? Fluit Other? No Yes When? Teta When was your last: Pap Smear? Breast Exam? Cholesterol check? Illness White Cancer (describe type) Hypertensions (high blood pressure) Heart Disease Diabetes Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases | immunization? |
| Hepatitis B? | Hepatitis B? No Yes When? Fluing Other? No Yes When? Tetal When was your last: Pap Smear? Breast Exam? Cholesterol check? Family History Has any member of your family (including parents Illness White Cancer (describe type) Hypertensions (high blood pressure) Heart Disease Diabetes Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases | immunization? |
| Hepatitis B? | Hepatitis B? No Yes When? Fluing Other? No Yes When? Tetal When was your last: Pap Smear? Breast Exam? Cholesterol check? Family History Has any member of your family (including parents Illness White Cancer (describe type) Hypertensions (high blood pressure) Heart Disease Diabetes Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases | immunization? |
| Other? | Other? No Yes When? Teta When was your last: Pap Smear? Breast Exam? Cholesterol check? Mammogram? Cholesterol check? Illness White Cancer (describe type) Hypertensions (high blood pressure) Heart Disease Diabetes Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases | anus immunization? |
| When was your last: Pap Smear? Mammogram? Cholesterol check? Prostate exam? Family History Has any member of your family (including parents, grandparents, and siblings) ever had the following? Illiness Which family members? Age when diagnosed Age when diagnosed Which family members? Age when diagnosed Which family members? Age when diagnosed Age when diagnosed Age when diagnosed Which family members? Age when diagnosed Age when diagnosed Beaching disease Diabetes Strokes Wential disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases Other Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.) Drug Name Dose Drug Name | When was your last: Pap Smear? Breast Exam? Mammogram? Cholesterol check? Family History Has any member of your family (including parents Illness White Cancer (describe type) | Stool check for blood? |
| Pap Smear? | Pap Smear? Breast Exam? Cholesterol check? | |
| ### Age when diagnosed Cholesterol check? Family History Has any member of your family (including parents, grandparents, and siblings) ever had the following? | Mammogram? Cholesterol check? | |
| Family History Has any member of your family (including parents, grandparents, and siblings) ever had the following? Illness | Family History Has any member of your family (including parents Illness White Cancer (describe type) Hypertensions (high blood pressure) Heart Disease Diabetes Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases | Prostate exam? |
| Illness | Illness Which Cancer (describe type) Hypertensions (high blood pressure) Heart Disease Diabetes Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases | |
| Illness | Illness Which Cancer (describe type) Hypertensions (high blood pressure) Heart Disease Diabetes Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases | s, grandparents, and siblings) ever had the following? |
| Hypertensions (high blood pressure) Heart Disease Diabetes Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases Other Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.) Drug Name Dose Drug Name Dose Drug Name Dose Prevention Do you wear seat belts? Do you wear a bike helmet? Do you wear a bike helmet? Do you wear a bike helmet? Do you exercise regularly? Yes No If yes, type, duration and number of times per week? Do you smoke? Do you smoke? Do you smoke? Do you drink alcoholic beverages? Do you drink coffee? Do you drink tea? If there is a gun in your home, do you keep it unloaded and out of children's reach? Do you drink dray? If there is a gun in your home, do you keep it unloaded and out of children's reach? Do you drink tea? If there is a gun in your home, do you keep it unloaded and out of children's reach? Do you use drugs? (marijuana, cocaine, crack, etc.) | Hypertensions (high blood pressure) Heart Disease Diabetes Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases | |
| Heart Disease Diabetes Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases Other Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.) Drug Name Dose | Heart Disease Diabetes Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases | |
| Diabetes Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases Other Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.) Drug Name Dose Drug Name Dose Drug Name Dose Drug Name Dose Drug Name Dose Drug Name Dose Prevention Do you wear seat belts? Do you wear as bike helmet? Yes No NiA Do you exercise regularly? Do you exercise regularly? Do you smoke? Do you drink alcoholic beverages? Do you drink alcoholic beverages? Do you drink coffee? Do you drink tea? If there is a gun in your home, do you keep it unloaded and out of children's reach? Do you drink coffee? Do you drink coffee? Do you drink coffee? Do you drink coffee? Do you drink bear Yes No Ni yes, how many cups per day? If there is a gun in your home, do you keep it unloaded and out of children's reach? Do you were worked with chemicals, paints, asbestos, or other hazardous materials? Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, brused) by your partner? Do you were feel afraid of your partner? Do you were feel afraid of your partner? Do you were feel afraid of your partner? Do you were feel afraid of your partner? Yes No Ni Yes No Ni Yes No If yes, explain: Yes No If yes, explain: Yes No If yes, explain: Yes No Yes No If yes, explain: Yes No Yes | Diabetes Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases | |
| Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases Other Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.) Drug Name Dose Drug Name Dose Drug N | Strokes Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases | |
| Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases Other Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.) Drug Name Dose Drug Name Dose Drug Name Dose | Mental disease (anxiety, depression, etc.) Drug or alcohol addiction Glaucoma Bleeding diseases | |
| Drug or alcohol addiction Glaucoma Bleeding diseases Other Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.) Drug Name Dose Drug Name Dose Drug Name Dose | Drug or alcohol addiction Glaucoma Bleeding diseases | |
| Bleeding diseases Other | Bleeding diseases | |
| Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.) Drug Name Dose Drug Name Dose Drug Name Dose Prevention Do you wear seat belts? Do you wear a bike helmet? Do you exercise regularly? Do you exercise regularly? Do you smoke? Do you drink alcoholic beverages? Do you drink tea? If yes, how many packs per day? Do you drink tea? If yes, how many packs per day? Do you drink tea? If yes, how many cups per day? Do you drink tea? If yes, how many cups per day? If yes, explain: Have you ever engaged in any activity which has put you at risk of getting AIDS? Do you wish to be tested for AIDS? Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Are you in a relationship in which you have been physically hurf (e.g., slapped, kicked, punched, bruised) by your partner? Do you ever feel afraid of your partner? Do you ever feel afraid of your partner? Yes No No NA | | |
| Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.) Drug Name Dose Drug Name Dose Drug Name Dose Prevention Do you wear seat belts? | Otner | |
| Prevention Do you wear seat belts? Do you wear a bike helmet? Do you wash a bike helmet? Do you wash a bike helmet? Do you smoke? Do you drink alcoholic beverages? Do you drink alcoholic beverages? Do you drink toeffee? Do you drink toeffee? Do you drink tea? Do you drink tea? Do you drink tea? If there is a gun in your home, do you keep it unloaded and out of children's reach? Do you use drugs? (marijuana, cocaine, crack, etc.) Have you ever engaged in any activity which has put you at risk of getting AIDS? Do you wish to be tested for AIDS? Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Are you in a relationship in which you have been physically hurt (e.g., stapped, kicked, punched, bruised) by your partner? Do you ever feel afraid of your partner? Do you ever feel afraid of your partner? Do you ever feel afraid of your partner? Do you ever feel afraid of your partner? Do you ever feel afraid of your partner? Do you ever feel afraid of your partner? Do you ever feel afraid of your partner? Do you ever feel afraid of your partner? Do you ever feel afraid of your partner? Do you ever feel afraid of your partner? Do you ever feel afraid of your partner? Do you ever feel afraid of your partner? Do you ever feel afraid of your partner? | | |
| Prevention Do you wear seat belts? | | |
| Do you wear seat belts? Do you wear a bike helmet? Do you exercise regularly? Do you smoke? Do you drink alcoholic beverages? Do you drink coffee? Do you drink tea? If yes, how many packs per day? If yes, how many cups per day? Do you drink tea? If yes, how many cups per day? If yes, explain: If yes, how many cups per day? If yes yes in a relation and number of times | Drug Name Dose Drug Name | Drug Name Dose |
| Do you wear seat belts? Do you wear a bike helmet? Do you exercise regularly? Do you smoke? Do you drink alcoholic beverages? Do you drink coffee? Do you drink tea? If yes, how many packs per day? Jes No If yes, how many packs per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, explain: Jes No If yes, how many cups per day? Jes No If yes, explain: Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes N | | |
| Do you wear seat belts? Do you wear a bike helmet? Do you exercise regularly? Do you smoke? Do you drink alcoholic beverages? Do you drink coffee? Do you drink tea? If yes, how many packs per day? Jes No If yes, how many packs per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, explain: Jes No If yes, how many cups per day? Jes No If yes, explain: Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes N | | |
| Do you wear seat belts? Do you wear a bike helmet? Do you exercise regularly? Do you smoke? Do you drink alcoholic beverages? Do you drink coffee? Do you drink tea? If yes, how many packs per day? Jes No If yes, how many packs per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, explain: Jes No If yes, how many cups per day? Jes No If yes, explain: Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes N | | |
| Do you wear seat belts? Do you wear a bike helmet? Do you exercise regularly? Do you smoke? Do you drink alcoholic beverages? Do you drink coffee? Do you drink tea? If yes, how many packs per day? Jes No If yes, how many packs per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes No If yes, explain: Jes No If yes, how many cups per day? Jes No If yes, explain: Jes No If yes, how many cups per day? Jes No If yes, how many cups per day? Jes N | | |
| Do you wear seat belts? Do you wear a bike helmet? Do you exercise regularly? Do you smoke? Do you drink alcoholic beverages? Do you drink coffee? Do you drink tea? If yes, how many packs per day? If yes, how many cups per day? Do you drink tea? If yes, how many cups per day? If yes, explain: If yes, how many cups per day? If yes yes in a relation and number of times | Prevention | |
| Do you wear a bike helmet? Do you exercise regularly? Do you smoke? Do you drink alcoholic beverages? Do you drink coffee? Do you drink tea? If yes, how many packs per day? If yes, how much per week? If yes, how much per day? If yes, how many cups per day? If yes, how many cups per day? If there is a gun in your home, do you keep it unloaded and out of children's reach? Do you use drugs? (marijuana, cocaine, crack, etc.) Have you ever engaged in any activity which has put you at risk of getting AIDS? Do you wish to be tested for AIDS? Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Do you ever feel afraid of your partner? Ves No No No N/A | | ☐ No I <u>f n</u> o, why not? |
| per week? | | |
| Do you smoke? Do you drink alcoholic beverages? Do you drink coffee? Do you drink tea? If yes, how many packs per day? Yes No If yes, how much per week? If yes, how many cups per day? If yes, explain: If yes, explain | Do you exercise regularly? | |
| Do you drink alcoholic beverages? Do you drink coffee? Do you drink tea? If there is a gun in your home, do you keep it unloaded and out of children's reach? Do you use drugs? (marijuana, cocaine, crack, etc.) Have you ever engaged in any activity which has put you at risk of getting AIDS? Do you wish to be tested for AIDS? Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Do you were feel afraid of your partner? Yes No If yes, how many cups per day? If yes, explain: Yes No If yes, how many cups per day? | | per week? |
| Do you drink coffee? Do you drink tea? If there is a gun in your home, do you keep it unloaded and out of children's reach? Do you use drugs? (marijuana, cocaine, crack, etc.) Have you ever engaged in any activity which has put you at risk of getting AIDS? Do you wish to be tested for AIDS? Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Do you drink coffee? No | | |
| Do you drink tea? If there is a gun in your home, do you keep it unloaded and out of children's reach? Do you use drugs? (marijuana, cocaine, crack, etc.) Have you ever engaged in any activity which has put you at risk of getting AIDS? Do you wish to be tested for AIDS? Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Do you ever feel afraid of your partner? No If yes, how many cups per day? If yes, how many cups per day? No If yes, explain: If yes, | | |
| If there is a gun in your home, do you keep it unloaded and out of children's reach? Do you use drugs? (marijuana, cocaine, crack, etc.) Have you ever engaged in any activity which has put you at risk of getting AIDS? Do you wish to be tested for AIDS? Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Do you ever feel afraid of your partner? Yes No No If yes, explain: Yes No No If yes, explain: Yes No | = · / · · · · · · · · · · · · · · · · · | |
| unloaded and out of children's reach? Do you use drugs? (marijuana, cocaine, crack, etc.) Have you ever engaged in any activity which has put you at risk of getting AIDS? Do you wish to be tested for AIDS? Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Do you ever feel afraid of your partner? No If yes, explain: Yes No If yes, explain: Yes No No If yes, explain: Yes No | | |
| Have you ever engaged in any activity which has put you at risk of getting AIDS? Do you wish to be tested for AIDS? Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Do you ever feel afraid of your partner? Yes No If yes, explain: | | _ |
| put you at risk of getting AIDS? Do you wish to be tested for AIDS? Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Do you ever feel afraid of your partner? Yes No If yes, explain: Yes No | | No If yes, explain: |
| Do you wish to be tested for AIDS? Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Do you ever feel afraid of your partner? Yes No If yes, explain: Yes No | | No If yes, explain: |
| Have you ever worked with chemicals, paints, asbestos, or other hazardous materials? Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Do you ever feel afraid of your partner? Yes No If yes, explain: Yes No | | ¬ № |
| asbestos, or other hazardous materials? Are you in a relationship in which you have been Yes No physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Do you ever feel afraid of your partner? | | |
| Are you in a relationship in which you have been Yes No physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Do you ever feel afraid of your partner? Yes No N/A | , | |
| physically hurt (e.g., slapped, kicked, punched, bruised) by your partner? Do you ever feel afraid of your partner? Yes No N/A | | |
| Do you ever feel afraid of your partner? | | □ No |
| | | □ No |
| B I MILL MIND | | _ |
| <i>,</i> — — — | | □ No □ N/A |
| Do you have a donor card? Yes No | Method of birth control? | □ No □ N/A □ No |