Patient Number _____

Name _____DATE OF BIRTH_____SEX_____

Marital Status Single _____Married _____Divorced _____Separated _____Widowed

FAMILY HISTORY

Do any of your blood relatives have: (Please check off those below that apply and the relationship to you)

Yes		Relationship
_____	Heart Disease	_____
_____	High Blood Pressure	_____
_____	Stroke	_____
_____	Diabetes	_____
_____	Epilepsy	_____
_____	Breathing Problems	_____
_____	Cancer	_____
_____	HIV	_____
_____	Other Condition	_____

Social History

Check off any item below that applies to you.

Smoke	_____	Amount _____
Alcohol	_____	Type/|Frequency _____
Drugs	_____	Type/Frequency _____
Caffeine (Coffee, Tea, Soda)	_____	Type/Frequency _____
Smoke Detectors	_____	How Many? _____
Seatbelts	_____	

Signature _____Date_____

DO NOT WRITE BELOW THIS LINE _____ OFFICE USER ONLY

Medical History

Allergies:

Medications _____

Environmental _____

Head/Neck_____

_____

Cardiac Disease _____

Hypertension _____

Circulatory _____

Cancer _____

Respiratory _____

Diabetes _____

Endocrine _____

Neuro (Seizures) _____

Psychiatric _____

GI Disorders _____

GU Disorders _____

Skin Diseases _____

Orthopedic _____

Surgery _____

_____

Hospitalizations/Accidents _____

Other _____

Height _____ Weight _____

Last CPX _____ Blood Work _____

Health Maintenance and Tests

	Date	Result
PPD	_____	
Td Booster	_____	
Flue Vaccine	_____	
Pneumovax	_____	
Other Vaccination	_____	

Sexual History

Hepatitis _____

GYN/Repro _____

STD _____

HIV/Hx HIV test _____

Mono _____ Homo _____ Bisexual _____

Feminine Health Maintenance and History

	Date	Result
Pap smear	_____	
Breast Exam	_____	
Mammogram	_____	

Gray _____ Para _____ _____ _____ _____

FT PT Ab L

Illness during Pregnancy _____

_____

Contraception _____

Signature _____

Date _____