MEDICAL HISTORY

Patient name: ______________________________ Date: ______________

- PLEASE LIST THE DATE & SUMMARY OF THE FOLLOWING:

Surgeries and Hospitalizations: Date: ____________ Summary: ______________________________
Date: ____________ Summary: ______________________________
Date: ____________ Summary: ______________________________

Illness other than surgery: Date: ____________ Summary: ______________________________
Date: ____________ Summary: ______________________________
Date: ____________ Summary: ______________________________

Immunization history (circle Yes or No): Pneumovax Y / N Date: __________ Flu shot Y / N Date: __________
Hepatitis B Y / N Date: __________ Tetanus Y /N Date: __________
Other ______________________________

When was your last: Pap Smear Date: __________ Breast Exam Date: __________ Mammogram Date: __________
Prostate Exam Date: __________ Stool check for blood Date: __________
Cholesterol check Date: __________

- FAMILY HISTORY: HAS ANY MEMBER OF YOUR FAMILY (INCLUSING PARENTS, GRANDPARENTS, AND SIBLINGS) EVER HAD THE FOLLOWING:

ILLNESS TYPE:	WHICH FAMILY MEMBER:	APPROX AGE DIAGNOSED:
Cancer of (type) __________		
Hypertension (high blood pressure)		
Heart Disease		
Diabetes		
Mental Illness (anxiety, depression,etc.)		
Other __________		

- MEDICATIONS (PRESCRIPTIONS, OVER THE COUNTER, VITAMINS, HERBS, ECT.)

Drug name / Dosage: ______________ Drug Name / Dosage: ______________
Drug name / Dosage: ______________ Drug Name / Dosage: ______________
Drug name / Dosage: ______________ Drug Name / Dosage: ______________

- PREVENTION (circle Yes or No):

Do you wear seat belts? Y / N If no why not? ______________________________
Do you wear a helmet? Y / N / NA
Do you smoke? Y/ N If yes how much per week? ______________________________
Do you drink alcoholic? Y / N If yes how much per week? ______________________________
Do you drink coffee? Y / N If yes how many cups per day? ______________________________
Do you drink tea? Y / N If yes how many cups per day? ______________________________
If you have a gun, is it out of your child's reach and unloaded? Y / N / NA
Do you use drugs (marijuana, cocaine, crack, etc.)? Y / N If yes explain: ______________________________
Have you ever engaged in any activity which has put you at risk of getting AIDS? Y / N If yes explain: ______________________________
Do you wish to be tested for AIDS? Y / N
Have you ever worked with chemicals, paints, asbestos, and other hazardous materials? Y / N
Are you in a relationship in which you have been physically hurt by your partner (slap, kicked, punched)? Y / N
Do you feel afraid of your partner? Y / N
Do you have a living will? Y / N Donor card? Y / N
Do you take a method of birth control? Y / N which one? ______________________________