Patient Name:_____ **Birthdate:** _____

Explain briefly why we need to see you today:

Surgeries:

Date	Operation

List current medications
(including over-the-counter, birth control pills):

Blood Transfusions:

Drug allergies and reactions:

Have you had a TB skin test? [ ] yes [ ] no
If yes, when?

Medical Problems: **(X any past or active problems)**
Give date when problem was found.

	When first diagnosed
[ ] Heart attack/Angina	_____
[ ] High Blood Pressure	_____
[ ] Diabetes	_____
[ ] Cancer & Leukemia	_____
[ ] Rheumatoid arthritis / Lupus	_____
[ ] Thyroid disease	_____
[ ] Pneumonia	_____
[ ] Asthma / Emphysema	_____
[ ] Blood Clots	_____
[ ] Bleeding Disorder	_____
[ ] Headaches/migraines	_____
[ ] Stroke or other nerve damage	_____
[ ] Tuberculosis	_____
[ ] Seasonal or year round allergies	_____
[ ] Jaundice or hepatitis	_____
[ ] Hernia or rupture	_____
[ ] Kidney or bladder problems	_____
[ ] Sexually transmitted disease	_____
[ ] Depression, nerves	_____
[ ] Arthritis	_____
[ ] Crohn's Disease or Ulcerative Colitis	_____

Family medical problems:

Health problems	Please mark Living	Deceased	Age
Father	[ ]	[ ]	___
Grandfather	[ ]	[ ]	___
Grandmother	[ ]	[ ]	___
Mother	[ ]	[ ]	___
Grandfather	[ ]	[ ]	___
Grandmother	[ ]	[ ]	___
Brother	[ ]	[ ]	___
	[ ]	[ ]	___
Sister	[ ]	[ ]	___
	[ ]	[ ]	___
Children	[ ]	[ ]	___
	[ ]	[ ]	___

Anyone with Tb? _____

Social History and Habits
Marital status: [ ] Single [ ] Married
[ ] Divorced [ ] Widowed
Do you smoke? [ ] yes [ ] no If no, have you ever smoked? [ ] yes [ ] no Quit date: _____
How many alcoholic beverages do you drink per week? _____

Please complete both sides of this form – Thank you!

Have you felt you should cut down? [ ] yes [ ] no
Have other criticized your drinking [ ] yes [ ] no
Have you felt guilty about drinking [ ] yes [ ] no
Have you drank first thing in the AM? [ ] yes [ ] no

Do you exercise? [ ] yes [ ] no Type: _____
How often per week? _____

Have you used illegal drugs? [ ] yes [ ] no

Have you been tested for Hepatitis C? [ ] yes [ ] no

Do you feel you are at risk for HIV/AIDS? [ ] yes [ ] no
Sex with women? [ ] yes [ ] no
Sex with men? [ ] yes [ ] no
More than one partner in the last 12 months? [ ] yes [ ] no
Blood transfusions – especially before 1985? [ ] yes [ ] no
Partner of person with HIV/AIDS? [ ] yes [ ] no

Do you use seat belts regularly? [ ] yes [ ] no

Preventative Health
Immunizations:
Last tetanus booster (need every 10 years) _____
Pneumonia vaccine (recommended for everyone over 65) and all smokers_____
Flu vaccine (recommended every fall for those over 6 months) _____
Hepatitis B series _____
Varicella (Chicken Pox) _____
Others _____

If over the age of 50 – have you been checked for colon Cancer in the past 3 – 5 years? [ ] yes [ ] no

Women only:
Date of last pap smear/pelvic exam: _____
Date of last mammogram: _____
Date of last period: _____

Men only:
Last time prostate was checked: _____

General Health:
Do you have any of the following? Please mark X

[ ] Frequent headache
[ ] Fevers/sweats
[ ] Vision problems
[ ] Dizziness or blackout
[ ] Hearing problems
[ ] Sinus / hay fever
[ ] Throat or swallowing problems
[ ] Chest Pain or tightness with exertion
[ ] Shortness of breath
[ ] Cough/sputum/blood
[ ] Wheezing
[ ] Palpitations
[ ] Frequent indigestion
[ ] Abdominal pain
[ ] Nausea/vomiting
[ ] Change in bowel habits
[ ] Bloody/black stools
[ ] Constipation/diarrhea
[ ] Pain with urination
[ ] Frequent urination
[ ] Bloody urine
[ ] Joint pain / stiffness
[ ] Seizures/numbness
[ ] Weakness
[ ] Excess sweating
[ ] Change in appetite
[ ] Weight Loss
[ ] Skin rashes

Please complete both sides of this form – Thank you!