PATIENT HISTORY

Patient Name ____________ Today's Date ____________

Social Security # ____________ Date of Birth: ____________

Past Medical History

Previous Physician's Name ____________ Date of last exam: ____________

Have you ever been hospitalized? O Yes O No If yes, describe: ____________

Have you ever been tested for hepatitis A/B/C? O Yes O No Which hepatitis virus? ____________

Have you ever been vaccinated for hepatitis B? O Yes O No If yes, date vaccine complete? ____________

Have you ever been vaccinated for hepatitis A? O Yes O No If yes, date vaccine complete?

Last Tuberculosis (TB) screening? ____________ Result of TB screening: O Positive O Negative

If positive TB screen, date of last chest x-ray? ____________ Result of chest x-ray: O Positive O Negative

Have you had a sexually transmitted disease? O Yes O No List diagnosis: ____________

Check any following conditions you are currently being treated OR have been treated for previously

O Heart Disease	O Asthma		O Shortness of breath	O Headaches/Migraines
O High Cholesterol	O Tonsillitis		O Lung Problems/Cough	O Neurological problems
O High Blood Pressure	O Seizures		O Sinus Problems	O Depression/Anxiety
O Low Blood Pressure	O Stroke		O Seasonal Allergies	O Psychiatric Care
O Heartburn (reflux)	O Diabetes		O Ear Problems	O Kidney/Bladder problems
O Anemia or blood problems	O Arthritis		O Eye disorder/Glaucoma	O Liver problems/hepatitis
O Swollen ankles	O Cancer		O Ulcers/Colitis	O Thyroid problems

Please describe any current or previous medical treatment not listed above:

____

____

Please list any previous surgeries (including dates)

____

____

Are you allergic to penicillin or any other dru O Yes O No

Please list all drug allergies: ____________

Medications (please list all currently taken) ____________

PLEASE CONTINUE TO PAGE 2 ↓

PATIENT HISTORY

Social and Preventative History

Do you currently smoke or chew tobacco? ○ Yes ○ No — If no, have you previously? ○ Yes ○ No

If so, how many packs per day? ________

Do you drink alcohol, beer, or wine? ○ Yes ○ No — If no, have you previously? ○ Yes ○ No

If so, how many drinks per week? ________ — Do you use a seatbelt while driving? ○ Yes ○ No

Do you currently drink coffee and/or tea? ○ Yes ○ No — How many cups per day? ________

Do you exercise daily/weekly? ○ Yes ○ No — Do you wear a helmet while riding a bike? ○ Yes ○ No

Family History

Relation	Living	Age (or age at death)	List serious illnesses
Mother	○ Yes ○ No		
Father	○ Yes ○ No		
Sisters	○ Yes ○ No		
	○ Yes ○ No		
	○ Yes ○ No		
Brothers	○ Yes ○ No		
	○ Yes ○ No		
	○ Yes ○ No		

Has any member of your family (including children and parents) had any of the following illnesses:

Illness	Which family member?	Additional Notes/Relevant Information
Anemia or blood disease		
Cancer		
Diabetes		
Glaucoma		
Heart Disease		
High blood pressure		
HIV disease/AIDS		
Mental Illness/Depression		
Stroke		
Other not listed		

Females: Gynecological History

How many times have you been pregnant?		Date of last pap smear:	
Have you had an abnormal pap smear?	○ Yes ○ No	Diagnosis & Follow Up:	
Have you had a sexually transmitted disease?	○ Yes ○ No	Last mammogram & results:	
Have you ever had a breast biopsy?	○ Yes ○ No	Biopsy results	

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Parent/Legal Guardian Signature ________________ **Date** ________