



Name: _____ DOB: _____ Age: _____ Date: _____

Current Medical Problems:

1. _____
2. _____
3. _____
4. _____

List Your Past Medical Problems:

1. _____
2. _____
3. _____
4. _____

List Your Surgeries and the Year:

1. _____
2. _____
3. _____
4. _____

List Hospitalizations and Year, Except for surgeries and child birth:

1. _____
2. _____
3. _____
4. _____

Check () any on going problems with:

- () Eyes
- () Ears / Nose / Throat
- () Heart
- () Lungs / Breathing
- () Stomach / Intestines
- () Kidneys / Bladder
- () Skin
- () Muscles / Bones / Joints
- () Brain / Headaches
- () Nerves / Emotions
- () Eating / Weight
- () Sleeping
- () Bleeding / Anemia
- () Energy
- () Any Other

Medicines Used Regularly:

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies:

Occupation: _____

Smoke: _____ Packs / Day x _____ years

Alcohol: _____ ounces per day

Caffeine: _____ cups per day

Women:

Number of Pregnancies: _____

Number of Deliveries: _____

Abortions/Miscarriages: _____

Birth Control: _____

List Any Serious Injuries:

1. _____
2. _____
3. _____

Significant Family History:

_____.

Month and Year of Last:

Tetanus Booster: _____

TB Tine Test: _____

Influenza Vaccine: _____

Pneumonia Vaccine: _____

Colonoscopy: _____

Breast X-Ray (Mammogram): _____

Bone Density Scan: _____

Cholesterol Test: _____

Physical Exam: _____

Sigmoidoscopy: _____

Glaucoma Test: _____

Hearing Test: _____