Name:_____ DOB:_____ Allergies to Medicines:_____

List Previous Medical Problems

1._____ 2._____ 3._____ 4._____
5._____ 6._____ 7._____ 8._____
9._____ 10._____ 11._____ 12._____

List Previous Surgeries and Approximate Dates

1._____ 2._____ 3._____ 4._____
5._____ 6._____ 7._____ 8._____

List Family's Medical History
Mother's Medical History:

_____

Father's Medical History:

_____

Brother's/Sister's Medical History:

_____

Other Relevant Family History:

_____

List Your Current Medications, dose, and frequency:

_____
_____
_____
_____
_____
_____
_____

Have you had a colonoscopy or EGD?
Results_____
Have you had a cardiac stress test?
Results_____

Smoking History: Have never smoked_____Still smoking_____ Quantity_____ Quit_____
Alcohol History: Never_____ Occasional_____ Moderate(quantity per week)_____
Recreational Drug Use: Never_____ Current/Prior use(drug and quantity)_____
Social History: circle one Married Single Re-married Divorced Separated Common-law Married Live with significant other. Do you have children?_____ How Many?_____
What kind of work do you do?_____

For Women, When was your last Well Woman Exam (include physician and results)

_____

When was you last Mammogram and results?

_____

For Men, When was your last prostate exam? (include physician and results)

_____