

REASON FOR VISIT

FAMILY HISTORY

DRUG ALLERGIES

**CURRENT MEDS
PRESCRIPTION & OVER THE COUNTER**

	FATHER	MOTHER	FATHER'S PARENTS	MOTHER'S PARENTS	SIBLINGS	CHILDREN
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon cancer/Polyps	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stomach/Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

HOSPITALIZATION OR SURGERY

Reason	Date	Reason	Date
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WOMEN ONLY Pregnant? Yes No Planning Pregnancy? Yes No

PAST MEDICAL HISTORY

- | | | | |
|----------------------------------------------|---------------------------------------------------|------------------------------------------------|------------------------------------------|
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Congenital heart disease | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Heart attack | <input type="checkbox"/> Gall bladder | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Allergies/hay fever | <input type="checkbox"/> Chest pain/angina | <input type="checkbox"/> Colon polyps | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Kidney disease | <input type="checkbox"/> Other |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Heart failure | <input type="checkbox"/> Menstrual dysfunction | |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Heart murmur | <input type="checkbox"/> Venereal disease | |
| <input type="checkbox"/> Dizziness/fainting | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Arthritis | |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Gout | |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Esophageal stricture | <input type="checkbox"/> Stroke/Tia's | |
| <input type="checkbox"/> Lung disease | <input type="checkbox"/> Ulcer | <input type="checkbox"/> Seizures | |

HABITS

Smoke: Packs daily _____
How long _____
When stopped _____

Alcohol: Type/Amount _____
How long _____
When stopped _____

Exercise routine: _____

Coffee: Cups daily _____
Drug Abuse: Type/Amount _____
How long _____
When stopped _____

Patient's Name: _____ Date: _____