Date ______________

Name ____ DOB ______________

Primary Care Physician ___________________________ **Referring Physician** _______________________

List all medication you take prescription and nonprescription

Primary Pharmacy ______________________________ No Medications_____

Medications	Medication Dose
1. ________________________	________________________
2. ________________________	________________________
3. ________________________	________________________
4. ________________________	________________________
5. ________________________	________________________
6. ________________________	________________________
7. ________________________	________________________
8. ________________________	________________________

Medication Allergies

Medication	Reaction
• ________________________	____________________
• ________________________	____________________
• ________________________	____________________
• ________________________	____________________

Past Medical History

(Closest date of diagnosis if known)

- o Alcohol Dependence __/__/___
- o Chronic Sinusitis __/__/___
- o Allergies (other)______________
- o Chronic Back pain __/__/___
- o Anxiety __/__/___
- o Diabetes Type 1 __/__/___
- o Anemia __/__/___
- Diabetes Type 2 __/__/___
- o Arthritis __/__/___
- o Depression __/__/___
- o Headaches/Migraines __/__/___
- o Insomnia __/__/___
- o Osteoarthritis __/__/___
- o Osteoporosis __/__/___
- o Tinnitus __/__/___

- o Rheumatoid Arthritis __/__/___
- o Seizures/ epilepsy __/__/___
- o Hyperthyroid __/__/___
- o Hypothyroid __/__/___
- o Other________________________
- o Cancer
  - Type:_______________ __/__/___
  - Type:_______________ __/__/___
- o Angina __/__/___
- o Atrial Fibrillation __/__/___
- o Atrial Flutter __/__/___

- Circular Disease______________
- Congestive Heart Failure __/__/__
- Heart Attack (MI) __/__/__
- Heart Failure __/__/__
- High Cholesterol __/__/__
- Hypertension __/__/__
- Hypotension __/__/__
- Palpitations __/__/__
- Stroke (CVA) __/__/__
- Varicose Veins __/__/__
- Other____________ __/__/__

- Asthma __/__/__
- COPD __/__/__

- Emphysema __/__/___
- Sleep Apnea __/__/___
- Other______________ __/__/___

- Colitis __/__/___
- Crohn's disease __/__/___
- Irritable Bowel Syndrome__/__/___
- Duodenal/ peptic ulcers __/__/___
- GERD (esophageal reflux)__/__/___
- Hepatitis A__ B__C_ __/__/___
  Other______________ __/__/___

Surgical History

- Angiography (heart cath)
- Angiography w/ Stent
- Appendectomy
- Arthroscopy Knee R)_ L)_
- Back surgery
  Type________________
- Biopsy Breast__ Liver_ Prostate__
  Other_____
- Bowel Resection
- Coronary Artery Bypass Graft (CABG)_
  #vessels_______
- Other______________

- Carpal Tunnel Release R)__L)__
- Cataract Extraction R)__L)__ __/__/___
- Cholecystectomy __/__/___
- Colonoscopy __/__/___
- Gastric Bypass __/__/___
- Hernia Repair __/__/___
- Hip Replacement R)__L)__ __/__/___
- Knee Replacement R)__L)_ __/__/___
- LASIK
- Open Reduction Internal Fixation (ORIF)
  Which limb_______ __/__/___
- Pacemaker __/__/___
- Thyroidectomy __/__/___
- Tonsillectomy __/__/___

Female Medical - Surgical History

- Augmentation Mammoplasty__/__/__
  Abnormal PAP __/__/__
- Bilateral Tubal Ligation __/__/__
  Uterine Fibroids __/__/__
- Abnormal PAP __/__/__
  Breast biopsy R_ L_ __/__/__
  Abnormal Mammogram __/__/__
  Mastectomy B)_R)_ L) __/__/__
- Cesarean Section __/__/__
  Childbirth __/__/__

- D & C (Dilation and Curettage)__/__/__
  Colposcopy __/__/__
- Endometriosis __/__/__
  Hysterectomy __/__/__
  T_ V_ P_ A_
- Other____________________ __/__/__
  Breast Reduction __/__/__

Male Medical, Surgical History

- Elevated PSA __/__/__
- Benign Prostatic Hyperplasia (BPH) __/__/__
- Impotence __/__/__
- Biopsy Prostate __/__/__
- Transurethral Resection of Prostate (TURP) __/__/__
- Vasectomy __/__/__

Family History

Please check any of the following conditions onset and/ or cause of death

- Adopted

	Mother	Father	Siblings (B/S)	Grandparent (P/M)	Child (S/D)	Cause of Death
Alcoholism	_______	______	_______	_______	________	Y N
Asthma	________	______	________	_______	________	Y N
COPD	_______	______	________	_______	_________	Y N
Congestive	_______	_______	_______	_______	_________	Y N
Heart Failure	_______	________	_______	________	_________	Y N
Heart Attack (MI)	_____	_______	_______	_______	_________	Y N
Stroke (CVA)	_______	_______	_______	________	________	Y N
Peripheral	________	_______	_______	________	________	Y N
Other	________	_______	_______	________	________	Y N
Cancer:	_________	_______	________	________	________	Y N
Type_____________						
Type_____________						
Diabetes	_________	_______	________	_______	________	Y N
High Cholesterol	_______	________	________	_______	________	Y N
Hypertension	_______	________	________	_______	________	Y N
Migraines	_______	________	________	________	________	Y N
Seizures, epilepsy	______	________	________	________	_______	Y N

Social History

Have you ever used tobacco? Yes___ No__ Currently Use__ Formerly Used___ Years Used__ Year Quit _______

Packs per day_______ Type: Cigarette___ Can__ Cigars__ Vapor__ Other__

Do you drink caffeine? Yes___ No___ Type ____________ ________ Amount Daily _________

Do you drink alcohol? Yes___ No ___ Type_____________ ________ Amount Daily__________

Currently__ Daily__ Weekly__ Occasionally__ Rarely___ Last Drink ____________

Immunizations- Please check and indicate immunization date to all that apply

Pneumococcal (PPV23) __/__/__ Influenza (LAIV) __/__/__ Adult Tetanus, Diphtheria, Pertussis (Tdap) __/__/__

Prevnar 13 __/__/___ Zoster __/__/__ Other: __________ Other:________ Other:_________

New patients please have consent form signed for release of Medical History from previous Medical Clinics.

Please bring the forms with you to your appointment. Thank you.