Name **Date of Birth**

Patient Information

Patient Information
Occupation:
Marital Status:
Wear glasses/contacts or hearing aids?

Medications and supplements

Name/Dose	Frequency/Directions

Allergies

Medication/Food/Other	Reaction

Medical History (Please circle)

Diabetes	Anemia/Blood Disease
High Blood Pressure	Thyroid Disease
High Cholesterol	Stomach/Intestinal Problems
Heart Disease	Urinary Problems
Lung Disease/Breathing Problems	Depression/Anxiety/Mental Illness/ADHD
Neurological Disease	Menstrual Issues
Kidney Disease	Sexually Transmitted Disease
Liver Disease	Serious Injury
Ear/Nose/Throat/Sinus Problems	Back/Neck Problems
Eye/Visual Problems	Joint Problems
Skin Issues	Cancer (Type):

Social History

Substance	**Amount/Previous Amount (Quit)**
Tobacco Products	
Alcohol	

Drugs/Recreational Substances	

Surgical History

Procedure	Date

Hospitalizations (Over 24 hour stay - not scheduled)

Reason	Date

Family History

Member/Age (Age of Death)	**Medical Issues/Cause of Death**
Father:	
Mother:	
Paternal Grandfather (Father's Father):	
Paternal Grandmother (Father's Mother):	
Maternal Grandfather (Mother's Father):	
Maternal Grandmother (Mother's Mother):	
Uncles:	
Aunts:	
Brother/Sister:	
Brother/Sister:	
Brother/Sister:	
Brother/Sister:	
Son/Daughter (Year of Birth):	
Son/Daughter (Year of Birth):	
Son/Daughter (Year of Birth):	
Son/Daughter (Year of Birth):	

Most recent

Name	**Date of Birth**
Family physician:	
Colonoscopy:	
Mammogram:	
Pap smear:	