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GENERAL MEDICAL INFORMATION

- Describe the current medical problem / reason for today's visit_____
- Present medications_____
- Allergies to medications_____
- Allergies (eg, itchiness or hives) to specific brands of soap/laundry detergent_____
- Other physicians currently treating you_____
- Previous or other medical problems_____
- List any previous surgeries or hospitalizations (include number of miscarriages and live births)

_____

- Females only: Are you pregnant, planning a pregnancy or nursing a child? ☐ Yes ☐ No
- Do You Smoke? ☐ Yes ☐ No ☐ Cigarettes ☐ Pipe ☐ Cigars Number of years _____
  How much? _____ Interested in stopping? ☐ Yes ☐ No
- Do you regularly drink alcohol? ☐ Yes ☐ No How many ounces/beers per day?_____
- Do you regularly drink coffee? ☐ Yes ☐ No How many cups per day?_____
- Are you under a lot of pressure at work? ☐ Yes ☐ No Please describe _____

PERSONAL MEDICAL HISTORY

Have you ever had any of the following (check all that apply)

☐ Chest pain/pressure/tightening	☐ Asthma	☐ Kidney Disease
☐ Hypertension	☐ Dizzy Spells	☐ Shortness of Breath
☐ Heart Attack	☐ Cancer	☐ TB/Lung Disorder
☐ Stroke	☐ Diabetes	☐ Ulcers
☐ Headaches	☐ Arthritis	☐ Skin Disorders
☐ Glaucoma	☐ Difficulty Hearing	☐ Hepatitis
☐ Allergies or Eczema	☐ Glaucoma	☐ Cataracts
☐ Depression	☐ Memory Loss	☐ Digestive Problems
☐ Blood in Stool	☐ Hemorrhoids	☐ Frequent Urinary Infections

☐ Other _____

IMMUNIZATIONS

(Year last received if known)

Smallpox_____
Tetanus_____
Typhoid_____
Polio_____
Influenza_____
Pneumonia_____
Rubella_____
Hepatitis_____

FAMILY HISTORY

	Father	Mother	Siblings	Children
Epilepsy				
Cancer				
Eczema / Psoriasis				
Heart Attack / Stroke				
Diabetes				
Asthma				
Hay Fever				
High blood pressure				