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## GENERAL MEDICAL INFORMATION

- *Describe the current medical problem / reason for today's visit__________________________
- Allergies to medications____________________________________________________________
- *Height ___________ *Weight_________
- 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?___________________

## 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 | _____ | _____ | _____ | _____ |