Medical History

Name _____ Date _____

Please List and Supply the Dates of:

Operations _____ _____ _____

_____ _____ _____

Hospitalizations other than for surgery _____ _____

_____ _____ _____

Immunization history—have you had:

Hepatitis B? ☐ No ☐ Yes When? _____

Other? ☐ No ☐ Yes When? _____

Pneumovax immunization? ☐ No ☐ Yes When? _____

Flu immunization? ☐ No ☐ Yes When? _____

Tetanus immunization? ☐ No ☐ Yes When? _____

When was your last:

Pap Smear? _____ Breast Exam? _____ Colon Cancer Test? _____

Mammogram? _____ Cholesterol check? _____ Prostate exam? _____

Family History Has any member of your family (including parents, grandparents, and siblings) ever had the following?

Illness	Which family members?	Age when diagnosed
Cancer (describe type)		
Hypertension (high blood pressure)		
Heart Disease		
Diabetes		
Strokes		
Mental disease (anxiety, depression, etc.)		
Drug or alcohol addiction		
Glaucoma		
Bleeding diseases		
Other _____		

Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose

Prevention

Do you wear seat belts?	☐ Yes	☐ No	If no, why not? _____
Do you wear a bike helmet?	☐ Yes	☐ No	☐ N/A
Do you exercise regularly?	☐ Yes	☐ No	If yes, type, duration and number of times per week? _____
Do you smoke?	☐ No	☐ Yes	If yes, how many packs per day? _____
Do you drink alcoholic beverages?	☐ No	☐ Yes	If yes, how much per week? _____
Do you drink coffee?	☐ No	☐ Yes	If yes, how many cups per day? _____
Do you drink tea?	☐ No	☐ Yes	If yes, how many cups per day? _____
If there is a gun in your home, do you keep it unloaded and out of children's reach?	☐ Yes	☐ No	☐ N/A
Do you use drugs? (marijuana, cocaine, crack, etc.)	☐ No	☐ Yes	If yes, explain: _____
Have you ever engaged in any activity which has put you at risk of getting AIDS?	☐ No	☐ Yes	If yes, explain: _____
Do you wish to be tested for AIDS?	☐ No	☐ Yes	
Have you ever worked with chemicals, paints, asbestos, or other hazardous materials?	☐ No	☐ Yes	If yes, explain: _____
Are you in a relationship in which you have been physically hurt (e.g., slapped, kicked, punched, bruised) by your partner?	☐ No	☐ Yes	
Do you ever feel afraid of your partner?	☐ No	☐ Yes	☐ N/A
Do you have a "living will"?	☐ Yes	☐ No	
Do you have a donor card?	☐ Yes	☐ No	

Method of birth control? _____

This information is for use by your physician as part of your confidential medical record.