| Last Name: | First Name: | Date of Birth: |
|---|---|---|
| Mailing address: | | |
| Preferred Phone: | Alternate Phone: | |
| Gender: Male Female | | |

## Patient and Family Medical History:

| Condition | Self | Father | Mother | Brother | Sister | Grandparent |
|---|---|---|---|---|---|---|
| AA- Aortic aneurysm | | | | | | |
| Alcoholism | | | | | | |
| Blood clotting disorder | | | | | | |
| CA- Breast cancer | | | | | | |
| CA- Cancer of colon | | | | | | |
| CA- Cancer of ovary | | | | | | |
| CA- Cancer of prostate | | | | | | |
| CA- Cancer of uterus | | | | | | |
| CA- Lung cancer | | | | | | |
| CHD- Coronary heart disease | | | | | | |
| Cystic fibrosis | | | | | | |
| DM- Diabetes mellitus | | | | | | |
| Dementia | | | | | | |
| Depression | | | | | | |
| Developmental disorder | | | | | | |
| Hemochromatosis | | | | | | |
| Hyperlipidemia | | | | | | |
| Hypertension | | | | | | |
| Kidney disease | | | | | | |
| Leukemia | | | | | | |
| Lupus | | | | | | |
| Lymphoma | | | | | | |
| Malignant melanoma | | | | | | |
| OP- Osteoporosis | | | | | | |
| Prolonged QT interval | | | | | | |
| RA- Rheumatoid arthritis | | | | | | |
| Respiratory disease | | | | | | |
| Sickle cell anemia | | | | | | |
| Stroke | | | | | | |
| Sudden cardiac death | | | | | | |
| TB- Tuberculosis | | | | | | |
| Thyroid disease | | | | | | |

| Social History: | Select Response | Past History: |
|---|---|---|
| **Tobacco Use** | Yes or No | Last use: |
| **Cigarette Smoking last 365 Days** | Yes or No | Last use: |
| **Alcohol** | Yes or No | Frequency:<br>Type: |
| **Substance Abuse** | Yes or No | Frequency:<br>Type: |
| **Sexual History** | Sexually Active<br>Yes or No | Self-Breast Exam: Y or N<br>Testicular Self-exam: Y or N or N/A<br>Menstrual Period Started: Y or N or N/A<br>Date of last Pap Smear: |
| **Exercise** | Yes or No | Frequency:<br>Type: |
| **Employment/School** | Employed<br>Retired<br>Unemployed<br>Other: | Hazardous equipment operation: Y or N<br>School concerns: (explain) |

| Health Maintenance | Date | Result |
|---|---|---|
| Colorectal Screening | | |
| Bone Density | | |
| Breast Cancer Screening | | |
| Lipid Screening | | |
| Depression Screening | | |
| Eye Exam | | |
| Fall Risk Screening | | |
| Flu (Influenza) Vaccine | | |
| Pneumococcal Vaccine<br>Dose 1: PCV 13 Vaccine | | |
| Pneumococcal Vaccine<br>Dose 2: PPSV 23 Vaccine | | |
| Tetanus Diphtheria Pertussis (TDAP) | | |
| Tetanus Diphtheria (TD) | | |
| Varicella (Chickenpox) Vaccine | | |
| Zoster (Shingles) Vaccine | | |
| Hepatitis A Vaccine | | |
| Hepatitis B Vaccine | | |
| Human Papillomavirus (HPV) Vaccine | | |
| Haemophilus influenzae type B (Hib) Vaccine | | |
| Measles, Mumps, Rubella (MMR) Vaccine | | |
| Meningococcal Vaccine | | |

**Surgical History:** _____

_____

**Previous Doctors and Specialties:** _____

_____

**Medication or Food Allergies:** _____

_____

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**List all Prescription and Over the Counter Medications on the Medication Form.**

**Any other concerns/problems:** _____

_____

**I have completed the above to the best of my knowledge.**

_____ _____

**Patient or Designee Signature** **Date**