Name Date

Date of Birth

Past Medical History (please circle)

Obesity	Ulcers	Depression or Anxiety
Hypertension	Irritable bowel disease	Suicide attempt
Heart Disease	Crohn's/Ulcerative colitis	Bipolar Mood Disorder
Heart Attack	Liver Disease	Valley Fever
Heart Failure	Bleeding tendency	Tuberculosis
Heart Valve Problems	Blood Clots	Positive TB test
Irregular Heart Beat	Anemia	Sleep Apnea
Emphysema/COPD	Cancer (Site_____)	Glaucoma
Asthma	Diabetes	Cataracts
Hives	Thyroid disease	Hearing Loss
Allergies/Hay fever	Osteoporosis	Prostate Disease
Kidney Disease	Arthritis	Sexually Transmitted Disease
Kidney Stones	Rheumatiod Arthritis	Hearing Loss
HIV	Lupus	Migraine
Hepatitis A, B or C	Gout	Seizure
Acid Reflux	Alcohol or Drug Dependency	Stroke

Other:

Surgical History

Heart Bypass
Heart Stent
Angioplasty
Tonsils
Appendix
Gall Bladder
Bariatric Surgery
Hysterectomy
D&C
Prostate
Hernia
Thyroid Surgery
Hip Replacement
Knee Replacement
Back or Neck Surgery
Cataracts
Sinus Surgery
Carotid Surgery
Spleen Removal
Colon or Bowel Surgery
Other:_____

Family History

Heart Disease/ Attack
Stroke
Diabetes
Sudden Death
Tuberculosis
Hepatitis
Bleeding Tendency
Blood Clots
Asthma or Emphysema
Depression or Anxiety
Mental Illness
Seizures
Crohn's Disease/Ulcerative Colitis
Breast Cancer
Prostate Cancer
Colon Cancer
High Blood Pressure
Kidney Disease
Family Violence or Abuse
Other:_____

Allergies

Penicillin
Sulfa
Codeine
Other:_____

OB/GYN for women

Pregnancy
How many?
Miscarriage
How many?
Living Children:_____
Abortion
First period (age _____)
Menopause (age_____)
Fertility treatments
Breast surgery
Abnormal Mammogram