Patient Name: ________________________ Date of Birth: ________________ Date: ____________

Medications with dose and frequency of use (including supplements, vitamins, etc..)

____

____

____

____

____

Allergies ☐No known allergies

____

____

Past Medical History - What Diagnoses/Conditions have you been given?

☐Allergies
☐Anemia
☐Angina
☐Anxiety
☐Arthritis
☐Asthma
☐Atrial fibrillation
☐BPH
☐Blood clots
☐Cancer (type: __________)
☐Cerebrovascular accident
☐COPD
☐Coronary artery disease
☐Crohn's disease
☐Depression
☐Diabetes
☐Gallbladder disease
☐GERD
☐Hepatitis C
☐Hyperlipidemia
☐High blood pressure
☐Irritable bowel disease
☐Liver disease
☐Migraine headaches
☐Heart Attack
☐Osteoarthritis
☐Osteoporosis
☐Peptic ulcer disease
☐Renal disease
☐Seizure disorder
☐Thyroid disease

Additional diagnosis/conditions: ____

Past Surgical History - What Surgeries/Procedures have you had?

____

____

____

____

Family History – What Diagnoses/Conditions are in your family history?

☐ Adopted, family history unknown

Family Member	Diagnosis	Age of Onset	Cause of Death
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N
			Y N

Patient Name: ___________________________ Date of Birth:__________________ Date: ______________

Social History

Marital Status/Family

Current Marital Status: ☐Married ☐Single ☐Divorced ☐Widow ☐Life partner

Do you have children? ☐ Yes, I have ____child(ren) ☐No

Tobacco Use

Do you or have you used tobacco? ☐Current ☐Former ☐Never

If current, what type of tobacco do you use?

☐chew ☐cigar ☐cigarettes ☐pipe ☐smokeless

How many units do you use per day? ____ How many years have you used tobacco? ____

Have you ever tried to quit? ☐No ☐Yes Year quit: ______

Alcohol

Do you drink alcohol? ☐Yes ☐No ☐Formerly; Year quit _____

If yes, what type? ☐beer ☐liquor ☐wine

How often? ☐daily ☐weekly ☐monthly ☐yearly ☐occasionally ☐rarely ☐socially

How much? ___________ When was your last drink? ___________________

Caffeine

Do you consume caffeine? ☐Yes ☐No

If yes, what type? ☐chocolate ☐coffee ☐soda ☐tablets ☐tea

How much do you consume per day? __________________

Lifestyle

What is your activity level? ☐moderate ☐sedentary ☐vigorous

What type of exercise do you do? ___________________________________ How often? ___________

What are you hobbies? ____

Have you had any changes in your sleep patterns? ☐Yes ☐No

If yes, what is the average number of hours of sleep per night? ______

Do you have trouble falling asleep? ☐Yes ☐No

Do you have difficulty staying asleep? ☐Yes ☐No

Do you have frequent waking episodes at night? ☐Yes ☐No

Do you have disrupted breathing, gasping, gagging, or choking for air during sleep? ☐Yes ☐No

Home environment/Safety

Do you have:

smoke detectors in home? ☐Yes ☐No

carbon monoxide detectors in home? ☐Yes ☐No

radon in home? ☐Yes ☐No ☐Treated ☐Untreated

Pool/spa at home? ☐Yes ☐No

home heating ☐coal ☐electric ☐gas ☐oil ☐solar ☐wood

use seat belt? ☐Yes ☐No

Health Maintenance – When was your last…

Colonoscopy? _________________ Result: ____

Mammogram? _________________ Result: ____

Dexa Bone Density Scan? _________________Result: ____

Pap Smear?__________________ Result: ____