Date:_____

Patient Name:_____

DOB:

PAST MEDICAL HISTORY: (PMH)

Unremarkable Abnormal Pap Smear	Gout GYN – # of Pregnancies
Alzheimer's Disease	GYN - # of Deliveries
	GYN - # of Miscarriages
Anxiety Arthritis	Hepatitis A
Asthma Atrial Fibrillation	Hepatitis C
	Hyperlipidemia
Autoimmune Disorder	Hypertension
Blood Transfusions	Hyperthyroidism
	Hypothyroidism Incontinence
Cancer - Breast	
	Inflammatory Bowel Disease
	Kidney Disease
	Kidney Stone
Cancer – Ovarian	
Cancer – Skin	
Cancer – Thyroid	Macular Degeneration
Chrohn's Disease	Migraine Headache
Chronic Low Back Pain	Multiple Sclerosis
	MI (Heart Attack)
Congestive Heart Failure	
Constipation, Chronic	
	Osteoporosis
Coronary Artery Disease	Parkinson's Disease
	Peptic Ulcer Disease
Degenerative Joint Disease	Polymylagia Rheumatica
Dementia	Psoriasis Decurrentiae
Depression	Polymylagia Rheumatica
Diabetes - Gestational	Rheumatoid Arthritis
Diabetes Type 1	Seizure Disorder
Diabetes Type 2	
	Urinary Tract Infections, Recurrent
	Varicose Veins
	CVN Lister "
Eczema	GYN History:
Fibromyalgia	Last Pap Smear Date:
GERD (gastric reflux)	Normal Abnormal
	Last Mammogram Date:
GI Bleed	
Other	HPV (Gardasil) ∐Yes ∐No
Other:	

DOB:	
DATE	DATE
Hernia – Incisional Hernia – Inguinal Hernia – Umbilical Hernia – Ventral Hysterectomy with tubes/ovaries removed Laminectomy Laminectomy Lap Band Procedure Lumpectomy (Breast lump removed) Mastectomy Eright Left Bilateral Mitral Valve Replacement Kidney Transplant Pacemaker Pacemaker Pacemaker Parathyroidectomy (Lung Removed) PTCA (Heart Stent) Rotator Cuff Repair Sinus Surgery Surgical Complication Tonsillectomy Tubal Ligation (tubes tied) Urinary Incontinence Surgery Vascular Surgery Vein Stripping	noved
	DATE Image:

Other: _____

Medications and How You Take Them (Include vitamins and herbals):

Name:	Strength:	Amount/day:
Name:	Strength:	Amount/day:

Dute:	
Patient Name:	DOB:

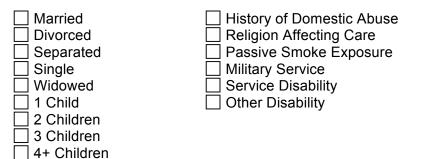
FAMILY HISTORY: (FH) (Limit to parents and/or siblings)

FH Growth/Development
FH Heart Disease
FH Hypertension
FH High Cholesterol
🗌 FH Kidney Disease
FH Lung Cancer
FH Lung/Respiratory
FH Melanoma
FH Migraines
FH Osteoporosis
FH Other Cancer (Specify Below)
🗌 FH Ovarian Cancer
FH Premenstrual Syndrome (PMS)
FH Psychiatric Care
FH Seizures
FH Severe Allergies
FH Stroke
FH Thyroid Problems
FH Uterine Cancer
FH Weight Disorder
FH Other Medical Problems (Specify Below)

Please specify which family member for each checked:



Date:



Date:	
Patient Name:	DOB:
RISK FACTORS: Please and factors.	swer the following questions in order to better assess your health risk
Tobacco Use:	
Currently Smoking <u>:</u> Cigarettes Cigars Smokeless/chewing	Amt: packs/day Amt: # per week Amt: per day
Previous Smoker: Year Started: Year Quit: Pack-Years: Comments:	
Never Smoked	
Passive Smoke Exposure (S	econd Hand Smoke): Yes No
Drug Use: None	
Other:	Marijuana Cocaine Crack Heroin Illegal Prescription Drugs
HIV High Risk Behavior:	
Alcohol Use: Yes	Νο
Drinks per Day: <a>[<1]	1 2 3 4 4+
If Yes: Type	
Caffeine Use: Drinks per Da	ıy: □0 □1 □2 □3 □4 □5+
Exercise: Times per Week	□1 □2 □3 □4 □5 □6 □7 □8+
Seat Belt Use: Percentage	of Time Used: 100 75 50 25 0