Name: _______________________________ male/female Age:_______ Today's Date:__________

Last first middle

Main reason for today's visit: _________________________ Weight: _________ Height: __________

Medications: *Please fill out the attached medications list*

Allergies - Have you ever had an allergic reaction to:

Penicillin ❑ yes ❑ no **Sulfa** ❑ yes ❑ no **Iodine** ❑ yes ❑ no **Adhesive Tape** ❑ yes ❑ no

Latex ❑ yes ❑ no **Other antibiotics:** ________________ **Other:** _______________________

Have you ever had a history of: Please circle current or past conditions

AIDS	Breast Lump	Epilepsy (Seizures)	High Cholesterol	Prostate Problems
Alcoholism	Bronchitis	Gout	Hypertension	Sleep Apnea
Asthma	Cancer	Heart Disease	Kidney Disease	Stroke
Anemia	Chemical Dependency	Heart Attack	Liver Disease	Thyroid Problems
Arthritis	Diabetes	Hepatitis	Multiple Sclerosis	Ulcers
Bleeding Disorder	Emphysema	Herpes	Pneumonia	Venereal Disease

Surgical History: Please circle and give approximate year of surgery

Cancer Surgery: year _________ **Cholecystectomy/Gallbladder:** year _________

Heart Bypass/Valve Replacement: year _________ **Hysterectomy/Tubular Pregnancy:** year _________

Carotid Surgery: year _________ **Hernia:** type________ year _________ **Appendectomy:** year _________

Vascular Surgery: year _________ **Abdominal surgery:** year _________ **Tonsillectomy:** year _________

Other: ______________________ year _________ **Other:** _____________________ year _________

Family History

Breast Cancer .... ❑ none ❑ mother ❑ father ❑ sister ❑ brother ❑ grandmother ❑ grandfather
Colon Cancer .... ❑ none ❑ mother ❑ father ❑ sister ❑ brother ❑ grandmother ❑ grandfather
Other Cancer .... ❑ none ❑ mother ❑ father ❑ sister ❑ brother ❑ grandmother ❑ grandfather
Depression .... ❑ none ❑ mother ❑ father ❑ sister ❑ brother ❑ grandmother ❑ grandfather
Diabetes .... ❑ none ❑ mother ❑ father ❑ sister ❑ brother ❑ grandmother ❑ grandfather
Heart Disease .... ❑ none ❑ mother ❑ father ❑ sister ❑ brother ❑ grandmother ❑ grandfather
Stroke............................ ❑ none ❑ mother ❑ father ❑ sister ❑ brother ❑ grandmother ❑ grandfather
High Blood Pressure ... ❑ none ❑ mother ❑ father ❑ sister ❑ brother ❑ grandmother ❑ grandfather
Chemical Dependency . ❑ none ❑ mother ❑ father ❑ sister ❑ brother ❑ grandmother ❑ grandfather
Thyroid Disease .... ❑ none ❑ mother ❑ father ❑ sister ❑ brother ❑ grandmother ❑ grandfather
Tuberculosis .... ❑ none ❑ mother ❑ father ❑ sister ❑ brother ❑ grandmother ❑ grandfather

Social History

Do you use alcohol? .... ❑ yes ❑ no ❑ never ❑ rarely ❑ moderately ❑ daily
Do you use tobacco? ... ❑ yes ❑ no Last used: ____________________________
Do you use drugs? ...... ❑ yes ❑ no Last used: ____________________________
Occupation? ____