NAME: _____ DOB:_____ SEX: M / F

Address: _____
PHONE: Home:_____ Cell:_____ Work:_____

PHARMACY: _____ Email address: _____

SOCIAL HISTORY: (please circle)
Marital Status: S / M / D /W Regular exercise: Y / N
Illegal Drugs: Y / N Homosexual: Y / N
Alcohol use: Y / N If yes, how many drinks per week? _____ per month?_____
Tobacco use: Cigarettes____Y /N Smokeless tobacco Y / N
How many pack per day _____ for how many years?_____
Former smoker: Number of years quit_____ (how many packs per day ____ for how many yrs?_____)

List all current medical problems:

List all past medical problems:

LIST ALL DRUG ALLERGIES: (Includes x-ray dye, etc)

List all current medications: (please include dosage) Also please include any over the counter medications (Vitamins,etc)**

FAMILY HISTORY: Please circle if a blood relative has had any of the following.

1. Heart attacks/heart disease
2. Strokes
3. High blood pressure
4. Diabetes
5. Colon polyps
6. Cancer_____
7. Allergies
8. Kidney stones
9. Tuberculosis
10. AIDS
11. Mental illness
12. Bleeding problems
13. Alcoholism
14. Asthma

Other:_____

	Age	Living	Deceased	Cause of death	Illnesses
FATHER					
MOTHER					
BROTHERS					
SISTERS					
CHILDREN					

LIST ALL PAST SURGERIES: (please list type and the date)

HEALTH MAINTENANCE: Have you had any of the following tests in the past?

Colonoscopy Y / N Date:_____
Pneumonia Vaccine Y/ N Date:_____
Treadmill cardiac screening Y / N Date: _____
Cholesterol screening Y/N Date:_____
Date:_____

Mammogram (if female) Y /N Date:_____
PAP Smear (if female) Y / N Date:_____
Bone density testing Y / N Date:_____
PSA/prostate exam (if male) Y / N