Name: _____ DOB:_____ SEX: M / F
Address: _____
Phone: Home: _____ Cell: _____ Work: _____
Pharmacy: _____ Email Address: _____

SOCIAL HISTORY *(please circle one):*
Marital Status: S M D W Regular Exercise: Y / N Homosexual: Y / N
Illegal Drugs: Y / N Alcohol Use: Y / N If yes, how many drinks per week? _____ per month? _____
Tobacco use: Y / N Smokeless Tobacco: Y / N
How many packs per day _____ for how many years? _____
Former smoker: Number of years quit _____ (*how many packs per day _____ for how many years? _____)*

List **ALL** current medical problems:

List **ALL** past medical problems:

LIST ALL DRUG ALLERGIES *(including x-ray dye, etc.):*

List **ALL** current medications *(please include dosage and any over the counter medications including vitamins):*

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					
Brother(s)					
Sister (s)					
Child(ren)					

List **ALL** past Surgeries *(please list type and date):*

HEALTH MAINTENANCE: Have you had any of the following tests in the past?
Colonoscopy: Y / N date: _____ Mammogram: Y / N date: _____
Pneumonia Vaccine: Y / N date: _____ PAP Smear (if female): Y / N date: _____
Treadmill Cardiac Screening: Y / N date: _____ Bone Density Testing: Y / N date: _____
Cholesterol Screening: Y / N date: _____ PSA / Prostate Exam (if male): Y / N date: _____