NAME _____ **Today's Date** _____/_____/_____

Date of birth: (month, day, year) _____/_____/_____

PAST MEDICAL HISTORY

Please check any previous medical problems you have had. PLEASE GIVE APPROXIMATE DATE OF ONSET

Arthritis _____ **Gout** _____ **Asthma** _____

High Blood Pressure _____ **Heart Attack:** _____ **Stroke** _____

Congestive Heart Failure _____ **Cancer:** _____ **Diabetes** _____

Kidney Stones _____ **Psoriasis** _____ **Osteoporosis** _____

Broken bones after 50 _____ **Thyroid Problems** _____ **Liver Disease** _____

Depression _____ **Fibromyalgia** _____ **Kidney Disease** _____

Seizures _____ **GERD (Reflux)** _____

Stomach or Duodenal Ulcer _____ **Gastrointestinal (GI) Bleed** _____

Other Illnesses (please describe) _____

_____

_____

PAST SURGICAL HISTORY

Please list any surgeries/operations you have had, with approximate dates, if known

_____

_____

_____

_____

_____

FAMILY HISTORY:

Do you know of any relative who has or has had (enter relationship: (M = mother, F = father, B= brother, S = sister, GM = grandmother, GF -= grandfather)

Arthritis	_____	**Gout**	_____	**Cancer**	_____
Diabetes	_____	**Lupus**	_____	**Blood Clots**	_____
Psoriasis	_____	**Stroke**	_____	**Colitis**	_____
High Blood Pressure	_____	**Tuberculosis**	_____	**Thyroid Disease**	_____
Heart Disease	_____	**Fibromyalgia**	_____	**Peripheral Neuropathy**	_____

Father alive_____ **deceased**_____ **if deceased, cause of death**_____

Mother alive_____ **deceased**_____ **if deceased, cause of death**_____

Number of siblings (sisters/brothers) living_____ **deceased**_____

Number of children_____ **List ages**_____

MARITAL STATUS

Never married ☐ **Married** ☐ **Widowed** ☐ **Divorced** ☐ **Separated** ☐

EDUCATION (circle highest level attended)
Grade School Junior High School 7 8 9 High School 10 11 12
College 1 2 3 4 Post College/Graduate School

OCCUPATION: (current) _____ (pre-retirement) _____
Retired ☐ Disability ☐ Temporary Medical Leave ☐ (date started)_____
If currently working, numbers of hours (average) per week_____

HABITS

Are you a smoker? YES ☐ NO ☐ If so, how many cigarettes per day do you smoke? _____
How many years have you been a smoker? _____ Did you smoke in past years? _____
How many cigarettes per day did you smoke?_____ How many years? _____

Do you drink alcohol? YES ☐ NO ☐ If so, average amount per week? _____
Did you drink alcohol in the past? ☐ If so, how much? _____

Do you Exercise? (Please describe and give frequency) _____
_____

Check symptoms you have had in the past 6 months or that are currently a problem for you
(Please mark C for current and P for past)

☐ Fatigue	☐ Fever/chills	☐ Skin rash	☐ Weight gain/loss or more than 10 lb
☐ Hair loss	☐ Mouth ulcers	☐ Dry eyes	☐ Fingers turning blue/white with cold exposure
☐ Cough	☐ Dry mouth	☐ Swollen glands	☐ Mouth sores/ulcers (inside mouth)
☐ Reflux	☐ Chest pain	☐ Eye redness/pain	☐ Shortness of breath
☐ Diarrhea	☐ Heartburn	☐ Bloody stools	☐ Pain with deep breathing
☐ Seizures	☐ Headaches	☐ Nausea/vomiting	☐ Pain or difficulty urinating
☐ Numbness/tingling of arms/ legs		☐ Depressed mood	

CURRENT MEDICATIONS

Name of medication	Dose	Frequency

ALLERGIES OR REACTIONS TO MEDICATIONS (Name of medication and reaction)

_____
_____
_____