MEDICAL HISTORY INFORMATION

Name_____ Date_____

Date of Birth_____ SSN_____ Gender at Birth: M F

Current Gender identity if different from above: M F Transgender

Primary Care Physician_____

Pharmacy and Location_____

Pharmacy Telephone # (if known) _____

Current Medications: Please write the name, dosage and number of times you take the medication on a daily basis. If you need more space please use the back of this page. Please include any over the counter medications that you take regularly.

Medication name	Strength	Times taken daily
Example: Losartan	10 MG	1tab twice a day

Immunizations: Please enter-to the best of your knowledge-the month/year that you last received any of the following.

	DATE		DATE		DATE
FLU		**Measles**		**Pneumonia**	
Hepatitis A		**MMR Series**		**Tetanus/TD**	
Hepatitis B		**OPV Series**		**Tuberculosis**	
Hep B Series		**IPV Series**		**Varicella**	

Social History:

Do you have a living will or advance directive? Yes_____ No____

If yes, have you given us a copy? Yes_____ No____

Alcohol Use:

How would you rate your intake of alcoholic beverages?

Never___ Social___ Occasional___ Moderate___ Heavy___

How many drinks do you have Daily____ Weekly____

Do you consider your intake of alcohol a problem? If so, would you like to quit? Yes__ No__
Have you ever tried to quit drinking? Yes__ No__

Tobacco Use

Non-smoker__ Cigarettes____ packs per day___ Pipe___ Cigars__ Snuff__ Chewing Tobacco__

Previous Smoker? Y N How long did you smoke? _____ At what age did you start _____

At what age did you stop? _____ How many packs a day did you smoke? ____

Have you ever tried to quit? Y N

Are you interested in stopping? Y N

Caffeine Intake

How would you rate your caffeine intake each day? (Coffee, tea, soda)

Daily use: ___1-3 ___ 4-6 ___ more than 6...cups/glasses/cans daily

Exercise History

Describe your activity level: Inactive___ Light ___ Moderate___ Heavy___ Vigorous___

Living Conditions

Live Alone____ With Parents____ With Relatives____ With Roommate____

With Spouse____ With Caregiver___ With Domestic Partner___ In a Group Home___

Assisted Living___ Nursing Home___ on Hospice___

Seat Belt Use

Do you wear your seat belt?

Always___ Almost always___ Occasionally___ Never___ Not Applicable___

Helmet Use

Do you wear a helmet when you ride a motorcycle, scooter, bike or skate?

Always___ Almost always___ Occasionally___ Never___ Not Applicable___

Drug use

Do you take, or have you ever taken or used any drugs other than over the counter medications that were not prescribed to you? Yes__ No__

If yes, please describe below.

Sexual Activity

I have never been sexually active___ I am sexually active___ Not currently sexually active___
Which of the following method/s of birth control are used?

None___ Condoms___ Foam/Jelly___ Implants___ Sponge___ Diaphragm___ Pill___ Rhythm___

Depo-Provera___ Vasectomy___ Tubal ligation___ Hysterectomy___

Women only

Do you have a menstrual cycle? Y N If not, how many years since your last cycle? ____
How many pregnancies? ____ How many live births? ____

How many times, if any, did pregnancy result in one of the following?

Still born____ Miscarriage____ Abortion____

Allergies: Please list your reactions, if you are allergic to any of the following. List any

Allergy	Reaction	Allergy	Reaction	Allergy	Reaction
ACE inhibitors Accupril/Monopril/Captopril		Erythromycin		Shellfish	
Adhesive tape		Iodine		Sulfa drugs	
Animal Dander		Latex		Tetracycline	
Anti-fungal creams		Milk		Theophylline	
Aspirin		Mites		OTHER	
Cephalosporin's		Molds			
Chocolate		NSAIDS- Advil, Ibuprophen etc.			
Codeine		Nuts			
Dust		Penicillin's			
Eggs		Pollen			

Family History: Enter the age at death, if family member is deceased. Check any significant diseases or conditions known for that relative under Medical Problems.

Example: Father	No age 87	Colon Cancer	alcoholism/cancer
Mother	Yes	N/A	hay fever/diabetic
Relative	**Living—Yes / No If no, age at death**	**Cause of Death**	**Medical Conditions**
Father			
Mother			
Brother #1			
#2			
#3			
#4			
Sister #1			
#2			
#3			
#4			
Son #1			
#2			
#3			
#4			
Daughter #1			
#2			
#3			
#4			

If more room is needed, please use back of page

Medical History: Enter the year that you were diagnosed with any of the conditions listed below. If your condition is not listed, please write in the specific diagnosis in the space provided under "other" and the year that you were diagnosed. Please only check those boxes that apply to you; all others leave blank.

Anemia/Easy Bruising		Heart Murmur		Sexual Problems	
Angina		Hepatitis or Jaundice		Skin Conditions	
Arthritis		Herpes		Stomach Ulcers	
Bursitis		High Blood Pressure		Tuberculosis	
Cancer/Type		Hyperthyroidism		Varicose Veins	
Chicken Pox		Hypothyroidism		Whooping Cough	
COPD		Kidney Failure			
Depression (severe)		Kidney Infection			
Diabetes		Kidney Stone			
Diverticulosis		Measles			
Epilepsy		Mental Illness			
Gall Bladder Disease		Migraines		**OTHER**	
German Measles		Mumps			
Gonorrhea		Paralysis			
Gout		Phlebitis			
Hay Fever		Rheumatic Fever			
Heart Attack		Scarlet Fever			
Heart Failure		Seizures			
Coronary Artery Disease					

Surgical History: Please enter the year and type of surgery, as close as you can recall, that was done. If you have had a surgical procedure that is not listed below, please write it in the heading—OTHER along with the year and type.

Description	Year	Dr / Hospital	Description	Year	Dr / Hospital
Appendectomy			Hysterectomy-Abdominal		
Back Surgery			Hysterectomy-Vaginal		
Blood Clots Removed			Hysterectomy-Partial		
Breast Implants or Removal			Hysterectomy-Total Abdominal/Vaginal		
Breast Reduction			Tubal Ligation		
Lumpectomy			Cataract		
Mastectomy			Gallbladder Removed		
Colon Removal Partial or Total			Cyst Excision		
Colonoscopy			Hemorrhoidectomy		
Colectomy/Ileostomy			Prostate Surgery (TURP)		
Angioplasty/Stent			Stomach Stapled / Shrunk		
Coronary Artery Bypass			Thyroid		
Aortic Valve (Heart) Replacement			Tonsillectomy		
Cardiac Catheterization					
Mitral Valve (Heart) Replacement					
Pacemaker			OTHER:		
Hernia Surgery or Repair					
Joint Replacement					
Hip					
Shoulder					
Knee					
Other					