

Past Medical History: (Please check all that apply)

Today's date: _____

<input type="radio"/> Anxiety Disorder	<input type="radio"/> Fibromyalgia	<input type="radio"/> Migraine Headaches
<input type="radio"/> Arthritis	<input type="radio"/> Gout	<input type="radio"/> MRSA Infections
<input type="radio"/> Asthma	<input type="radio"/> Has pacemaker	<input type="radio"/> Mumps
<input type="radio"/> Bleeding Disorder	<input type="radio"/> Heart Attack	<input type="radio"/> Osteoporosis
<input type="radio"/> Cancer	<input type="radio"/> Hepatitis	<input type="radio"/> Pneumonia
<input type="radio"/> Chicken Pox	<input type="radio"/> Hive or Eczema	<input type="radio"/> Seizure Disorder
<input type="radio"/> Depression	<input type="radio"/> Kidney Disease	<input type="radio"/> Scarlet Fever
<input type="radio"/> Diabetes- Insulin	<input type="radio"/> Kidney Stones	<input type="radio"/> Stroke
<input type="radio"/> Diabetes Non-Insulin	<input type="radio"/> Learning Disabilities	<input type="radio"/> Whooping Cough
<input type="radio"/> Difficulty in Urinating	<input type="radio"/> Liver Disease	<input type="radio"/> Other, Explain _____
<input type="radio"/> Diverticulitis	<input type="radio"/> Measles	

Drug Allergies: _____

Past Surgical / Hospital History:

Surgery/Hospitalizations	Reason	Year	Hospital
1.			
2.			
3.			
4.			
5.			

Family Health History:

Relation (please check across all that apply or indicate type)	Alive y/n	Age	Alcoholism	Anemia	Cancer/ type	Diabetes	Heart Disease	Hypertension	Kidney Disease	Liver Disease	Mental Disorder / type	stroke	Thyroid Disorder
Grandmother (maternal)													
Grandfather (maternal)													
Grandmother (paternal)													
Grandfather (paternal)													
Father													
Mother													
Brother/Sister 1.													
2.													
3.													
4.													

Social Information:

	Yes/No	Details (how many, where, who)
Exercise		
Live with		
Personal Safety		
1. Have you been hit, punched, strangled or threatened to hurt you?		
2. Do you wear a seat belt?		
Do you wear or need glasses or contacts?		
Do you wear or need a hearing aid?		
Do you use a cane, walker or wheelchair?		
Weight at Birth		
Pregnancy or Birth Complications:		
Locations patient has gone for immunizations:		