

SS# \_\_\_\_\_ Name: \_\_\_\_\_ Sex: M / F Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Other Phone \_\_\_\_\_  
 Occupation \_\_\_\_\_ Marital Status \_\_\_\_\_ Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_  
 Insured Name \_\_\_\_\_ Birth Date \_\_\_\_\_ SS# \_\_\_\_\_ Relationship to insured \_\_\_\_\_

**Drug Allergies**

**Current Meds**

**Hospitalization or Surgery**

Reason	Date	Reason	Date

**Family History**

	Father	Mother	Father's Parents	Mother's Parents	Siblings	Children
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy/Convulsions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding Disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Women Only:** Pregnant? Yes No Planning Pregnancy? Yes No

**Medical History**

<input type="checkbox"/> Hypertension	<input type="checkbox"/> Dizziness / Fainting	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Hyperlipidemia	<input type="checkbox"/> Anxiety	<input type="checkbox"/> GI Disorder
<input type="checkbox"/> Heart palpitations	<input type="checkbox"/> Fatigue	<input type="checkbox"/> Sexual dysfunction
<input type="checkbox"/> Heart murmur	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Menstrual dysfunction
<input type="checkbox"/> Arrhythmia	<input type="checkbox"/> Orthopnea	<input type="checkbox"/> Incontinence
<input type="checkbox"/> Chest pain / Angina	<input type="checkbox"/> Allergies / Hay fever	<input type="checkbox"/> Anemia
<input type="checkbox"/> MI	<input type="checkbox"/> Asthma	<input type="checkbox"/> Arthritis
<input type="checkbox"/> Stroke / TIAs	<input type="checkbox"/> COPD	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Claudication	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Gout
<input type="checkbox"/> Congestive heart failure	<input type="checkbox"/> Venereal disease	<input type="checkbox"/> Diabetes
<input type="checkbox"/> Congenital heart Disease	<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Endocrine disease
<input type="checkbox"/> Headache	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Other
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Liver disease	

**Habits**

<input type="checkbox"/> Smoke: Packs daily How long? Interested in stopping?	<input type="checkbox"/> Coffee: Cups daily Other caffeine	<input type="checkbox"/> Sleep: Difficulty falling asleep Continuity Disturbances Snoring Early morning awakening Daytime drowsiness Other
<input type="checkbox"/> Exercise routine:	<input type="checkbox"/> Alcohol: Type Amount	
	<input type="checkbox"/> Diet: Salt Intake Fat Intake	

**Hepatitis C risk factor:**  Blood transfusion prior to 1992  IV drug use (1+ times)  Contact with blood / bodily fluid

Signature \_\_\_\_\_ Date \_\_\_\_\_