Current medical problems_____
_____
_____
_____

Past medical problems/Hospitalizations (approx dates)_____
_____
_____
_____

Past surgeries (approx dates)_____
_____
_____

Allergies:_____

Medication/dosages:_____
_____
_____
_____
_____

Have you ever been diagnosed with any of the following:

__ Anemia
__ Arthritis
__ Asthma
__ Cancer
__ Colon problems
__ COPD/emphysema
__ COVID-19
__ Cystic fibrosis
__ Diabetes
__ Gallstones
__ Glaucoma
__ Hearing loss
__ Heart dz/ heart attack
__ Heart valve disease
__ Hernia
__ High blood pressure
__ High cholesterol
__ HIV
__ Irregular heartbeat
__ Liver disease/hepatitis
__ Mental illness
__ Neuropathy
__ Pancreatitis
__ Reflux
__ Sickle cell
__ Speech problems
__ Stroke
__ TB
__ Ulcer
__ Vision loss

Any other conditions not listed above?_____
_____
_____
_____

When was your last tetanus shot?_____

List any other adult immunizations (flu, shingles, pneumonia, COVID-19, etc.) with dates if known
_____
_____
_____

Screening exams: (answer as best as you can remember)
When was your last colonoscopy?_____
When were you last checked for blood in your stool?_____
When was your last prostate exam/PSA?_____
When was your last mammogram?_____
When was your last breast exam?_____
When was your last Pap smear?_____
When was your last eye exam?_____

For females only:
How many total pregnancies/ deliveries have you had?_____
How many miscarriages/Elective abortions have you had?_____
Are you pregnant now?_____
When was your last period?_____
If you are menopausal, at what age?_____

Family History:

Mother - If living what is her age? If not living what was the cause of her death and age at death?_____

Listen any of her pertinent medical history_____

_____

Father - if living what is his age? If not living what was the cause of his death and age at death?_____

List any of his pertinent medical history_____

_____

Siblings - how many siblings do you have? How many male/female? How many living/deceased? What medical problems do they have?_____

_____

_____

_____

Please list any other pertinent medical conditions that run in your family

_____

_____

Social History:

Are you: Married ____ Single____ Widowed _____ Divorced_____

Spouses name:_____

Occupation:_____

Tobacco use:

Current smoker - # of years/# packs per day_____

Past smoker - # of years/# packs per day/quit date_____

Smokeless tobacco - past or current user? How many years? Number of cans/ packages a day?_____

Alcohol use:
If current user, describe frequency and how much_____
_____
If past user, describe frequency/how much/ date quit_____
_____

Street drug use:
Please list past or current usage of any illicit drugs and what types_____
_____

Prescription drug use:
Please indicate if you feel you have had a problem with use of prescription drugs and what they were/are_____
_____

Is there anything else not covered on this form that you would like us to know regarding your health to include any concerning symptoms you may have?
_____
_____
_____
_____
_____

Patient's signature:_____ **Date:**_____