



**Medical History**

<u>Self</u>		Specify	<u>Family</u>		Relationship/Specify	
Yes	No		Yes	No		
<input type="checkbox"/>	<input type="checkbox"/>	_____	Alcohol/Drug Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Blood Disorders	<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"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Gastrointestinal Problems (e.g., hepatitis, colitis, ulcers)	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<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"/>	_____	Kidney/Bladder Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental Health Problems (e.g. bipolar, depression, anxiety, suicide, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Respiratory Disease (e.g., asthma, emphysema)	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Seizure/Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin Problems	<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"/>	_____	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	_____
<input type="checkbox"/>	<input type="checkbox"/>	_____	Other Medical Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____

**Health Risks: Please help us evaluate areas of potential health risks by answering the following:**

- | Yes                      | No                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | Type and amount of tobacco used (per day): _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Number of alcoholic drinks per week: _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Has <u>your</u> alcohol use ever interfered or caused problems with your relationships, or job/school performance? |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever used recreational drugs? If yes, specify the type: _____   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you usually wear a seatbelt?  |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you have a serious concerns regarding weight/eating disorder?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you ever been forced into unwanted sexual activity?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you feel sad or anxious most of the time?   |
| <input type="checkbox"/> | <input type="checkbox"/> | Have you seriously considered suicide in the past year?  |

**Immunizations:**

- Have you had the chicken pox or the vaccine?  Yes  No  
 When was your last Tetanus vaccine? \_\_\_\_\_  
 Have you ever had a positive  
 Tuberculin (TB) Skin Test?  Yes  No

**FEMALES Only:**

- Last Pap Smear: \_\_\_\_\_  
 Ever had an abnormal Pap Smear:  Yes  No  
 Explain if Yes: \_\_\_\_\_  
 Last breast exam\*: \_\_\_\_\_  
 Last mammogram: \_\_\_\_\_  
 Birth control method: \_\_\_\_\_  
 Ever been pregnant? \_\_\_\_\_

**MALES Only:**

- Last testicular exam\*: \_\_\_\_\_  
 Last prostate exam: \_\_\_\_\_  
 \*Testicular self exams are recommended monthly for all men.

\* Monthly self-breast exams and annual gynecology exams are recommended for all women. Women 40 and older should have annual mammograms (earlier in some circumstances).

Patient's Signature

Date