DEMOGRAPHICS	
Name:	
Date:	SSN:
Address:	
Phone:	Work #:
Cell Phone:	DOB:
Preferred Pharmacy:	
Living Will: Y N	Routine Physical: Y N

HOSPITALIZATION / SURGERY	
DATE	REASON

LIFE STYLE			
Marital Status:	S M D W		
Tobacco:	Chew	Smoke	How Much
Alcohol:	Y	N	How Much
Other Drugs:	Y	N	How Much
Caffeine:	Y	N	How Much
Exercise:	Y	N	How Much
Salt intake:		Fat intake:	
Occupation:			

MEDICATIONS (attach additional page if needed)		
NAME	DOSE	FREQUENCY

IMMUNIZATIONS	DATE
Tetanus	
Flu Shot	
Pneumonia	
Hepatitis B	
Hepatitis A	

FOOD/DRUG ALLERGIES

FEMALES	
#Pregnancies:	#Miscarriages:
#Abortions:	#Live Births:
Length of Cycle:	Days of Flow:
Cramps: Y N	Clots: Y N
Irregular: Y N	Self Breast Exam Y N
First day of last period:	
Family Hx Cancer: Y N	Hot Flashes: Y N
Night Sweats: Y N	Sexually Active: Y N
Colorectal Screening/Date:	Normal: Y N
Last Mammogram/Date:	Normal: Y N
Last Bone Density/Date:	Normal: Y N
Last Pap Smear/Date:	Normal: Y N

MALES	
Sexually Active:	Y N
Penile Discharge:	Y N
Penile Lesions:	Y N
Hernia:	Y N
Sexual Difficulties:	Y N
Urinary Hesitancy:	Y N
Sexually Transmitted Disease:	Y N
Nighttime Urination:	Y N
Colorectal Screening/Date:	Normal Y N
Prostate Exam/Date;	
PSA/Date:	

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CURRENT MEDICAL PROBLEMS								
High Blood Pressure	Y	N	Diabetes	Y	N	High Cholesterol	Y	N
Asthma	Y	N	Tremors	Y	N	Obesity	Y	N
Depression/Anxiety	Y	N	Migraines	Y	N	Osteoporosis	Y	N
Difficulty Swallowing	Y	N	Glaucoma	Y	N	Freq. Ear Infections	Y	N
Dizziness	Y	N	Visual Problems	Y	N	Nose Bleeds	Y	N
Sinus Problems	Y	N	Hayfever/Allergies	Y	N	Cancer	Y	N
Chronic Cough	Y	N	Chest Pain	Y	N	Murmur	Y	N
Swollen Ankles	Y	N	Leg Pain	Y	N	Varicose Veins	Y	N
Loss of Appetite	Y	N	Indigestion	Y	N	Nausea Vomiting	Y	N
Peptic Ulcers	Y	N	Abdominal Pain	Y	N	Gall Bladder Trouble	Y	N
Jaundice/Hepatitis	Y	N	Bowel Changes	Y	N	Constipation/Diarrhea	Y	N
Ulcerative/Crohn’s	Y	N	Diverticulosis	Y	N	Bloody/Black Stool	Y	N
Hemorrhoids	Y	N	Hernia	Y	N	Urine Problems	Y	N
Kidney Stones	Y	N	Sex. Trans. Disease	Y	N	Chronic Fatigue	Y	N
Weight Loss	Y	N	Urethral Discharge	Y	N	Anemia	Y	N
Thyroid Disease	Y	N	Seizures	Y	N	Stroke	Y	N
Muscle Weakness	Y	N	Numbness/Tingling	Y	N	Frequent Headaches	Y	N
Recurrent Back Pain	Y	N	Bone Fracture	Y	N	Joint Injury	Y	N
Arthritis/Gout	Y	N	Rashes/Hives	Y	N	Psoriasis/Eczema	Y	N
Memory Loss	Y	N	Nervous/Moody	Y	N	Phobias	Y	N
Mental Illness	Y	N	Lactose Intolerance	Y	N	Tuberculosis/PPD	Y	N

FAMILY HISTORY

Please note history of Alcoholism, Asthma, Bleeding Disorder, Cancer, Diabetes, Glaucoma, Seizures, Heart Disease, High Blood Pressure, Mental Illness, Migraines, Osteoporosis, Stroke, Thyroid Disease, Genetic Abnormalities, Depression, Alzheimer’s Disease, or other medical problems.

	Age		Medical Problems	Living?
Mother:				Y N
Father:				Y N
Siblings:	M	F		Y N
	M	F		Y N
	M	F		Y N
	M	F		Y N
Children:	M	F		Y N
	M	F		Y N
	M	F		Y N
	M	F		Y N
Grandparents:				Y N
Other				