Last Name _____ **First Name** _____ **DOB** _____ **Today's Date** _____

Current Medications (Including Over the Counter):		
Name of Medication	Dose (include strength and number of pills per day)	Prescribed by:

Medication Allergies	**Reaction**

Medical History (Circle those that apply)				
Diabetes (type)	Heart Murmur	Cataracts	Jaundice	Migraines
High or Low Blood Pressure	Heart Problems	Kidney Disease	Hepatitis	Anxiety
High Cholesterol	Pneumonia	Kidney Stones	HIV/AIDS	Depression
Thyroid Trouble or Goiter	Stroke	Crohn's Disease	Tuberculosis	Skin Disorder
Cancer (type)	Asthma	Colitis	Stomach Ulcer	Eating Disorder
Leukemia	Epilepsy or Seizure	Anemia	Gallstones	Rheumatic Fever
Excessive Bleeding After Injury or Dental Work	Swollen or Painful joints	Pain or Pressure in Chest	Palpitation or Pounding of Heart	Recent Gain or Loss of Weight
Suicide Attempt or Plans	Shortness of Breath	Chronic Cough	Stomach, Liver or Intestinal Trouble	Frequent Trouble Sleeping

Surgical History (include date of surgery)	**Hospitalizations (include dates and reason)**

Social History	**Circle**	**Frequency/Amount**
Tobacco use?	Y/N	How many/often?
Alcohol use?	Y/N	How much/often?
Drug use?	Y/N	Type? How much/often?
Caffeine use?	Y/N	How many/often?

Family History	**Circle One**	**Age**	**Health Issues/ Cause of death if deceased**
Father	Alive/Deceased		
Mother	Alive/Deceased		
Paternal Grandfather	Alive/Deceased		
Paternal Grandmother	Alive/Deceased		
Maternal Grandfather	Alive/Deceased		
Maternal Grandmother	Alive/Deceased		
Siblings: Brothers #_____ Sisters#_____		Children: Sons#_____ Daughters#_____	