



Name: _____ DOB: _____ Age: _____ Date: _____

Current Medical Problems:

1. _____
2. _____
3. _____
4. _____

List Your Past Medical Problems:

1. _____
2. _____
3. _____
4. _____

List Your Surgeries and the Year:

1. _____
2. _____
3. _____
4. _____

List Hospitalizations and Year, Except for surgeries and child birth:

1. _____
2. _____
3. _____
4. _____

Check () any on going problems with:

- () Eyes
- () Ears / Nose / Throat
- () Heart
- () Lungs / Breathing
- () Stomach / Intestines
- () Kidneys / Bladder
- () Skin
- () Muscles / Bones / Joints
- () Brain / Headaches
- () Nerves / Emotions
- () Eating / Weight
- () Sleeping
- () Bleeding / Anemia
- () Energy
- () Any Other

Medicines Used Regularly:

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies:

Occupation: _____
Smoke: _____ Packs / Day x _____ years
Alcohol: _____ ounces per day
Caffeine: _____ cups per day

Women:
Number of Pregnancies: _____
Number of Deliveries: _____
Abortions/Miscarriages: _____
Birth Control: _____

List Any Serious Injuries:

1. _____
2. _____
3. _____

Significant Family History:

_____.

Year of Last:
Tetanus Booster: _____
TB Tine Test: _____
Cholesterol Test: _____
Physical Exam: _____
Breast X-Ray (Mammogram): _____
Sigmoidoscopy: _____
Glaucoma Test: _____
Hearing Test: _____