



Full Name: _____ Birth Date: _____ Today's Date: _____
 Gender / Identity: _____ Personal Pronouns: _____
 How did you hear about our office? _____

PERSONAL MEDICAL HISTORY

DISEASE / CONDITION	CURRENT	PAST	COMMENTS
Alcoholism			
Asthma			
Cancer (<i>type: _____</i>)			
COPD			
Depression /Anxiety/Insomnia			
Diabetes (<i>type: _____</i>)			
Heart Disease			
High Blood Pressure (<i>Hypertension</i>)			
High Cholesterol			
Kidney (<i>Renal</i>) Disease			
Migraines/Headaches			
Stroke			
Other:			
Other:			

MEDICATIONS

NAME, DOSE & FREQUENCY

ALLERGIES

SURGERY / HOSPITALIZATIONS HISTORY

TYPE (<i>Specify Left / Right</i>)	DATE	LOCATION/FACILITY

ADDITIONAL HEALTH HISTORY

Vasectomy:	Bone Density / DEXA:
Colonoscopy:	

WOMEN'S HEALTH HISTORY

Date of last period:	Age of First Period:
Total Number of Pregnancies:	Age of Menopause:
Number of Children:	
Pregnancy Complications:	
Date of Last Pap Smear:	History of Abnormal Pap? Yes / No
Date of Last Mammogram	History of Abnormal Mammogram? Yes / No

SOCIAL HISTORY

Occupation:	Drink Alcohol? YES / NO
Marital Status (<i>circle one</i>): Single, Married, Divorced, Separated, Partner, Spouse	Use Tobacco/Nicotine? YES / NO
Recreational or Illicit Drugs?	Drink Pop/Caffeinated beverages? YES / NO
Do you Exercise? YES / NO	

FAMILY MEDICAL HISTORY

DISEASE / CONDITION	FAMILY MEMBER / AGE
Alcoholism	
Asthma	
Cancer (<i>type: _____</i>)	
COPD	
Depression /Anxiety/Insomnia	
Diabetes (<i>type: _____</i>)	
Heart Disease	
High Blood Pressure (<i>Hypertension</i>)	
High Cholesterol	
Kidney (<i>Renal</i>) Disease	
Migraines/Headaches	
Stroke	
Other:	
Other:	

IMMUNIZATIONS (*include date*)

Tetanus:	Pneumonia:	Shingrix	COVID-19
----------	------------	----------	----------

Do you have a Living Will and/or Durable Power of Attorney for your Health Care? YES / NO

Patient Name (*please print*): _____

Patient Signature: _____ **Today's Date:** _____

Physician Signature: _____ Today's Date: _____