

SOCIAL HISTORY: Fill in the Circles

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Marital Status: Single Married Divorced Widowed Significant Other

Living Arrangements; With Spouse or Significant other Alone Child (ren)
 Nursing Home Other

Tobacco Use: Never Current Use Former Use Quit Date_____

Type of Tobacco_____ How many Packs/Day____ or How much__

How many Years

Alcohol Use: Never Current Use Former Use

___ Drinks per day ___ Drinks per Week ___ Drinks per Month _____ Year Quit

Illicit Drug Usage: Never Current Type?_____ Date Quit_____

OCCUPATION HISTORY:

Primary Occupation_____ Secondary Occupation_____

Occupational Exposure_____ Type & Date_____

EDUCATION / COMMUNICATION

Your Highest Level of Education_____

Your Preferred language_____ Do you use interpreter **YES NO**

Do you understand spoken English **YES NO** written English **YES NO**

Can you hear well **YES NO** Can you see well **YES NO**

Can give your health Information to_____

PERSONAL HISTORY:

HEALTH MAINTANENCE:

PROCEDURE	YES	NO	If yes DATE	Normal or Abnormal	State Type of test you had
Influenza Vaccine				*****	*****
Pneumonia Vaccine				*****	*****
Colorectal Screening					
Mammogram					
PAP Smear(F)					*****
Prostate Screening(M)					
Dexa Scan					

TRANSFUSION HISTORY:

O No Transfusions O Had Transfusion DATES:
 O Transfusion Product O How many Units
 Transfusion Reaction **YES NO** (Circle one)

Women only:

Age first period started _____
 Date of Last Menstrual Period _____ Menopausal **Yes or No**
 Age at first pregnancy _____ Number of Live births _____
 Number of Miscarriages _____ Number of Children breast fed _____
 Did you use contraceptives: **Yes or No** ** If Yes Type _____
 Have you taken Hormone Replacement RX **Yes or No**
If Yes Year started _____ Year stopped _____
 Type of Hormones used _____

FAMILY HISTORY:

RELATIONSHIP	If Living	Age	If Died	Age	Major Illness	Age of onset
Mother						
Father						
Sister						
Sister						
Brother						
Brother						

FAMILY SPECIFIC MEDICAL HISTORY:

Heart Disease Diabetes

Cancer Type:

Breast Ovary Uterus Cervix Prostate Colon Lung

Pancreas Stomach Thyroid Blood Other Cancers

Did you or family have any genetic testing for risk of cancer or other disorders?

ALLERGIES:

Name of Allergy	Severe	Moderate	Mild	Treatment if any

YOUR MEDICATION LIST (including Herbals, Vitamins and supplements)

Date started	Drug	Dose	How often

If list is too long please attach a separate sheet

PAST /PRESENT MEDICAL HISTORY (circle YES or NO)

Disease	Yes	No		Disease	Yes	No
Arthritis	Yes	No		Pneumonia	Yes	No
Asthma	Yes	No		Tuberculosis	Yes	No
Birth defects	Yes	No		Infectious Mono	Yes	No
Bleeding Tendency	Yes	No		High Blood Counts	Yes	No
Cancer	Yes	No		Low Blood Counts	Yes	No
Colitis	Yes	No		Sickle cell Anemia	Yes	No
Diabetes	Yes	No		Blood Clots (Lung)	Yes	No
Emphysema	Yes	No		Blood Clots (Other)	Yes	No
Epilepsy	Yes	No		Infectious Mono	Yes	No
Glaucoma	Yes	No		Hepatitis	Yes	No
Goiter	Yes	No		Thyroid Problems	Yes	No
Heart Problems	Yes	No		Kidney Disease	Yes	No
Hernia	Yes	No		Bladder Problems	Yes	No
High Blood Pressure	Yes	No		Venereal Disease	Yes	No
Low Blood Pressure	Yes	No		AIDs or HIV Positive	Yes	No
Head Aches	Yes	No		Rheumatic Fever	Yes	No
Stroke	Yes	No		Stomach Problems	Yes	No

LIST ALL MAJOR ILLNESSES/ NON- SURGICAL HOSPITALIZATIONS

Date	Illness/ Diagnosis	Treatment

REVIEW OF SYSTEMS: mark X only if these symptoms are present

SYMPTOMS	YES	SYMPTOMS	YES	SYMPTOMS	YES
General***		Respiratory ***		Musculo Skeletal	
Weight loss		Cough		Muscle Pain	
Fatigue		Sputum Production		Stiffness	
Loss of Appetite		Cough up Blood		Joint Pain	
Night Sweats		Out of Breath on Exertion		Joint swelling	
Fever		Difficulty breathing at rest		Back Pain	
Chills		Difficulty Breathing while lying down		Skin***	
Eyes ***		Gastrointestinal***		Rashes	
Blurred Vision		Nausea		Burning	
Double Vision		Vomiting		Itching	
Difficulty Seeing		Heartburn		Neurologic	
Ears,Nose,Mouth,Throat*		Constipation		Headaches	
Hearing Loss		Diarrhea		Seizures	
Ringing in Ears		Abdominal pain		Dizziness	
Sinus trouble		Rectal bleeding		Loss of Balance	
Trouble Swallowing		Bowel Incontinence		Weakness of Limbs	
Sore Throat		Genital/Urinary***		Loss of Sensation	
Nasal Drainage		Vaginal Bleeding		Tingling Sensation	
Nose bleeds		Burning on urination		Memory Loss	
Hoarsness		Pain with urination		Difficulty thinking	
Cardiac (Heart) ***		Blood in Urine		Psychiatric	
Chest Pains		Frequent Urination		Nervousness	
Heart Palpitations		Urinary Incontinence		Depression	
Light Headedness		Abnormal Bleeding***		Restlessness	
Swelling in legs		Bruising		Difficulty Sleeping	
Episodes of fainting		Excessive Bleeding		Immunologic***	
Endocrine***		Craving for ice		Frequent Infections	
Goiter		Lumps***		Mouth sores	
Heat or Cold intolerance		In the Arm Pits		Allergies	
Increased Thirst		In the Groin		AIDS/HIV Positive	
Increased Urination		In the Neck		Venereal Diseases	

To the best of my knowledge, the questions on this form have been accurately answered. I understand that incorrect information can harm my health.

You can share my health Information with other healthcare providers involved in my care and third party payers like Insurers. You can also share my health information with _____

 Name _____ Signature _____ Date _____