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MEDICAL INFORMATION

Name (Last, first, middle initial)	☐ M ☐ F	Date of birth	Today's date

Medical problems: List all medical problems you are aware of or have been diagnosed with:

Medications: List all medications you are currently taking. Include over-the-counter medications and supplements.

Drug allergies: Yes___; No ___ Allergies to medications, X-Ray dyes, other substances, and/or med. Intolerances.

Medication/Substance Reaction/Intolerance	Type of Reaction

Past surgeries / year ❑ None		
	1	
	2	
	3	

Past hospitalizations: ❑ None

Immunizations Approx. dates:	☐ Tetanus/diphtheria/pertussis ________ ☐ Influenza ____________	☐ Pneumonia ____________ ☐ Other ____________________

Family history: Has any member of your family (parents and siblings only) had any of the following?

Illness	Family member	Illness	Family member
Cancer (type)		Mental illness (type)	
High blood pressure		Alcohol/drug abuse	
Heart disease		High cholesterol	
Diabetes mellitus		Dementia	
Other		Other	

For women: Gynecological and obstretic history

# of pregnancies _______ Births _________ Miscarriages ______ Abortions _________

Any abnormal pap smears Yes ____ No _____ If yes When and what happened afterward?

Date of last pap smear? ____________ What, if any, method of birth control do you use? __________________

Name of gynecologist: ____

Important information

Do you smoke? ____ Yes ____ No If yes, how many packs per day and for how many years? _________________

Are you a former smoker? _____ Yes _____ No. If yes, quit date ___________

Do you drink alcohol? _____ Yes _____ No If yes, how many drinks per week:_______ Type of alcohol ___________

Have you used recreational drugs? _____Yes _____ No. If yes, what type? When did you last use? _____________

Do you exercise? _____ Yes _____ No If yes, what type____________________How often per week ________

History of sexually transmitted disease? _____ Yes _____ No. If yes, what type, and when ___________________

Is there anything else you would like me to know? (Please use reverse side if necessary.)