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Name \_\_\_\_\_ Date Today \_\_\_\_\_

Last First Initial Maiden Name  
 Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Your Family Doctor \_\_\_\_\_ Referring Doctor (if any) \_\_\_\_\_

Your Current Occupation \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Date of Birth \_\_\_\_\_ Your Age \_\_\_\_\_ Marital Status: \_\_\_ Married \_\_\_ Single \_\_\_ Divorced \_\_\_ Separated \_\_\_ Widowed

Your Social Security Number \_\_\_\_\_ Spouse Name \_\_\_\_\_

Spouse Occupation and Work Phone \_\_\_\_\_ Spouse Social Security # \_\_\_\_\_

Parent Name (if under 18) \_\_\_\_\_ Parent Social Security # \_\_\_\_\_

1. Do you have or have you ever had any of the following symptoms, diagnoses, or procedures?

	Yes	No		Yes	No		Yes	No
Crushing Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Severe Back Pain	<input type="checkbox"/>	<input type="checkbox"/>	Extreme Forgetfulness	<input type="checkbox"/>	<input type="checkbox"/>
Irregular Heart Rhythm	<input type="checkbox"/>	<input type="checkbox"/>	Spina Bifida	<input type="checkbox"/>	<input type="checkbox"/>	Multiple Sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Cardiac Catheterization	<input type="checkbox"/>	<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy or Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Bypass Surgery	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Deafness	<input type="checkbox"/>	<input type="checkbox"/>
Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Von Willebrand Disease	<input type="checkbox"/>	<input type="checkbox"/>
Other Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Venous Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/ARC	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Sugars	<input type="checkbox"/>	<input type="checkbox"/>	Attempted Suicide	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis or Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Cancer or Leukemia	<input type="checkbox"/>	<input type="checkbox"/>	Other Mental Disorder	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Ulcerative Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Anorexia or Bulimia	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Scarring	<input type="checkbox"/>	<input type="checkbox"/>
Crohn's Disease	<input type="checkbox"/>	<input type="checkbox"/>	Drug Dependency	<input type="checkbox"/>	<input type="checkbox"/>	Severe Anesthesia Rxn.	<input type="checkbox"/>	<input type="checkbox"/>
Diverticulitis	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	Other _____		

2. Reason for Today's Visit \_\_\_\_\_

3. Please list all serious medical illnesses and dates (i.e. diabetes, liver/kidney disease, cancers, etc.):

7. Please indicate the Number of:

Term pregnancies \_\_\_\_\_ Preterm pregnancies \_\_\_\_\_  
 Miscarriages \_\_\_\_\_ Abortions \_\_\_\_\_

4. Current Medications and Dosages:

8. Has anyone in your immediate family (mother, father, sibling, grandparent, or child) ever had:

- Breast Cancer
- Ovarian Cancer
- Uterine Cancer
- Colon Cancer
- Heart Disease
- Diabetes

5. Birth Control (Please check one or more):

- None-Not trying to avoid pregnancy
- Menopause
- Birth Control Pills
- Partner had Vasectomy or Hysterectomy
- Abstinent or Not Sexually Active
- Natural Family Planning
- Prior Tubal

9. Prior Surgeries and Year Performed:

10. Last date of following studies and results:

	Date	Normal	Abnormal	Abnormal In Past
Pap smear	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Mammogram	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colonoscopy	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
DEXA	_____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

6. Have you ever smoked?  Yes  No

Do you smoke now?  Yes  No

Year you quit smoking (if applies): \_\_\_\_\_

If you smoke now, how many packs/day? \_\_\_\_\_

11. Drug allergies and type of reaction to each drug:

