Patients Name:

____D.O.B.______________________

Health Information

Please check any and all medical problems that may apply.

__ High Blood Pressure
__ High Cholesterol
__ Heart Problems
__ Glaucoma
__ Stroke
__ Seizures
__ Headaches/Migraines
__ Depression/Anxiety
__ Vascular Disease
__ Cancer (where?)____________

__ COPD
__ Asthma
__ Other Lung Disease
__ Sinus Problems
__ Allergies
__ Acid Reflux (GERD)
__ Gastritis
__ Gallbladder Disease
__ Hepatitis/Liver Disease
__ Diverticulosis

__ Diabetes
__ Thyroid
__ Anemia
__ Kidney Problems
__ Kidney Disease/Stones
__ Urinary problems
__ Prostate Disease
__ Constipation
__ Skin Problem

List Any Other Medical Problems:

____
____
____

Please List Any Surgeries/Hospitalizations (including Year)

____/__________________
____/__________________
____/__________________
____/__________________
____/__________________

Allergies: Please list any allergies and reaction to them, if you have no allergies please write NONE.

____
____
____
____

Medication List

Medication:	Dosage:	Frequency:
1)	/	/
2)	/	/
3)	/	/
4)	/	/
5)	/	/
6)	/	/
7)	/	/
8)	/	/
9)	/	/
10)	/	/

Patients Name:

____D.O.B.______________________

Social History

Tobacco Use ______ a day, number of years ______ Year Quit ______
Alcohol Use ______ drink per week
Street Drugs ______
Exercise _________ type, low fat diet? _______
Drink Water ______ cups per day
Caffeine _________ cups per day
Sleep well? _______

Preventive Care

Colonoscopy? ______________ Date _____________ Results/Findings _______________
Rectal Exam? ______________ Date______________ Results/Findings _______________
Fecal Occult Blood Test______ Date______________ Results/Findings _______________
Glaucoma Testing __________ Date______________ Results/Findings _______________

Immunizations

Flu shot________________Date______________
Pneumonia shot_________ Date______________
Tetanus shot____________ Date______________
Hepatitis B shot_________ Date______________
Shingles shot____________Date______________

Pharmacy name: ____ Number_________________________

Primary Care Physician: ___________________________________ Number ______________________