

Patient name: _____ Date of birth: _____

**Medications – List all medications you currently take, the dosage, and how often you are taking them
Include all prescription and non-prescription (over-the counter, vitamins, supplements) medications**

I do not take any medications

Medication Name	Dose	Directions	Medication Name	Dose	Directions

Medication and Food Allergies – List all known allergies and/or sensitivities (drugs, food, animals, etc.)

No known allergies and/or sensitivities

Health Maintenance – Check all that apply and provide the date and where it was most recently completed

Exam	Date	Doctor/Facility	Exam	Date	Doctor/Facility
<input type="checkbox"/> Stool Blood Test			<input type="checkbox"/> Hepatitis C Screening		
<input type="checkbox"/> Colonoscopy (colon or rectal cancer test)			<input type="checkbox"/> Mammogram (breast cancer test)		
<input type="checkbox"/> DEXA Scan (bone scan)			<input type="checkbox"/> Pap Test (cervical cancer test)		
<input type="checkbox"/> Echocardiogram (heart ultrasound)			<input type="checkbox"/> Breast Exam		
<input type="checkbox"/> Pulmonary Function Test (lung test)			<input type="checkbox"/> Pneumonia Vaccine		
<input type="checkbox"/> Exercise Test (heart stress test)			<input type="checkbox"/> Influenza Vaccine		
<input type="checkbox"/> Eye Exam			<input type="checkbox"/> Shingles Vaccine		
<input type="checkbox"/> Foot Exam			<input type="checkbox"/> Tetanus Vaccine		

Medical History – Please list any known health conditions and the date you were diagnosed

Date	Health Condition	Date	Health Condition

Do you have an Advance Directive? Yes No
 Do you have a Living Will? Yes No

Do you have a Medical Power of Attorney? Yes No

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Surgical/Hospitalization History – Please list any previous surgeries and/or hospitalizations and the date they occurred			
Date	Surgery/Hospitalization	Date	Surgery/Hospitalization

Family History – If Parent (P), Siblings (S), Children (C), or Grandparent (GP) had any of the following, please indicate relative relationship			
<input type="checkbox"/> Diabetes	Relative:	<input type="checkbox"/> Heart Disease/Attack	Relative:
<input type="checkbox"/> Cancer	Relative:	<input type="checkbox"/> Heart Failure	Relative:
<input type="checkbox"/> Glaucoma	Relative:	<input type="checkbox"/> Kidney Disease	Relative:
<input type="checkbox"/> High Blood Pressure	Relative:	<input type="checkbox"/> Stroke	Relative:
<input type="checkbox"/> High Cholesterol	Relative:	<input type="checkbox"/> Other	Relative:

Work History – Please list any potential exposures you might have encountered during your work, military, or volunteer history		
		Duration in Years
Occupation		
Military Service & Occupation Specialty		
Volunteer Service		
Exposure	<input type="checkbox"/> Toxic chemicals (paint, fuels, fertilizers, pesticides, weed killer, cleaning agents, lead, arsenic, chloroform, solvents)	
	<input type="checkbox"/> Radiation (X-ray, atomic weapon production/testing/use, nuclear waste)	
	<input type="checkbox"/> Respiratory (gas, fumes, dust, asbestos)	
	<input type="checkbox"/> Biological materials (blood, bodily fluids)	
	<input type="checkbox"/> Combat	
	<input type="checkbox"/> Agent Orange	
	<input type="checkbox"/> Contaminated water	
	<input type="checkbox"/> Excessive noise and/or vibration (aircraft, construction, factory)	
	<input type="checkbox"/> Excessive sun (farming, ranching, construction)	
	<input type="checkbox"/> Excessive or long-term stress	
<input type="checkbox"/> Other		

Social History		
Have you ever smoked?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, for how many years? _____ Quit date: _____
Do you currently smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many packs do you smoke a day? _____
Do you vape?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how often? Daily _____ Weekly _____ Monthly _____
Do you consume alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, how many drinks do you consume in a day? _____
		If yes, how many drinks do you consume in a week? _____