Name:___________________________ **DOB:**_____________ **SSN:**____-__-______ **Date:**___________

PAST MEDICAL HISTORY: (Check if ***the patient*** has ever had or been diagnosed with any of the following)

☐ Alcoholism	☐ Endometriosis	☐ Irritable Bowel Syndrome
☐ Anemia	☐ Epilepsy/Seizures	☐ Kidney Infection
☐ Anxiety	☐ Eye problems	☐ Kidney Stones
☐ Arthritis	☐ Erectile Dysfunction	☐ Mental Illness
☐ Asthma	☐ Esophageal Reflux	☐ Obesity
☐ Back Aches	☐ Fibrocystic Breast Disease	☐ Ovarian Cysts
☐ Bronchitis	☐ Gallbladder Problems	☐ Pneumonia
☐ Enlarged Prostate	☐ Genital Warts	☐ Premenstrual Syndrome
☐ Cancer _____________	☐ Gonorrhea	☐ Rheumatic Fever
☐ Cervical Dysplasia	☐ Heart Attack	☐ Stroke
☐ Chlamydia	☐ Heart Murmur	☐ TIA
☐ Congestive Heart Failure	☐ Heart Disease	☐ Transfusion
☐ COPD	☐ Hepatitis __________	☐ Trichomonas
☐ Deep Vein Thrombosis	☐ Herpes, Genital	☐ Tuberculosis
☐ Depression	☐ High Blood Pressure	☐ Ulcers
☐ Diabetes Type I	☐ High Cholesterol	☐ Uterine Fibroids
☐ Diabetes Type II	☐ Hyperthyroidism	☐ Yellow Jaundice
☐ Ear Ache	☐ Hypothyroidism	☐ Other ________________
☐ Emphysema	☐ Infertility	____________________________

Medication Allergies: ____

PAST SURGICAL HISTORY: (Please check any the ***the patient*** has had and the date performed)

☐ Appendectomy______	☐ Gallbladder_____	☐ Laparoscopy _____	☐ Vaginal _____
☐ Breast _____	☐ Heart ______	☐ Oophorectomy ___	☐ Vasectomy ____
☐ Cesarean _________	☐ Hernia Repair ____	☐ Tonsillectomy ____	
☐ D&C __________	☐ Hysterectomy ___	☐ Tubal Ligation ____	
☐ Other _____________			

SOCIAL HISTORY:

Marital Status: ____Single ____Married ___Divorced ___Widowed ____In relationship w/significant other
Pregnancies: ___Total number Children: ___Total number ___Boys, ages_____ ___Girls, ages _____
Occupation: _____________________ ___Full-time ___Part-time
Do you exercise: __None ___ Occasionally ___ Regularly
Are you sexually active: ___Yes___No Do you use any contraceptives: ___No ___Yes (if so, what kind)________
Tobacco Use: ___Never ___Current ___Former Amount________ Started_______ Stopped ________
Alcohol Use: ___Never ___Current ___Former Amount ________ Started _______ Stopped ________
Recreational Drug Use: ___Never ___Current ___Former Amount ______ Started______ Stopped ________

FAMILY HISTORY: (Please check any family members that have had the following)

	Mom	Dad	Brother	Sister	Mom's Mother	Mom's Father	Dad's Mother	Dad's Father	Aunt	Uncle
Alcoholism										
Cancer										
COPD										
Depression										
Other Mental Illness										
Diabetes										
Heart Disease										
High Blood Pressure										
High Cholesterol										
Stroke										
Thyroid										
Other										
Still living?										