MEDICATIONS / ALLERGIES

Please list any allergies to any medications, and what reaction you have: _____
_____
_____

Please list medications currently taken, their dosages, and how many times per day you take them:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

FAMILY MEDICAL HISTORY

Please check any major illness in your family members (mother/father, brother/sister or children):

☐ Tuberculosis	☐ High Blood Pressure	☐ Thyroid Disease	☐ Seizures
☐ Emphysema		☐ Anemia	☐ Cancer
☐ Heart Disease	☐ Osteoporosis	☐ Blood Disorder	_____
☐ Liver Disease	☐ Diabetes	☐ Kidney Disease	☐ _____

PERSONAL INFORMATION

Please write in or circle information that applies to you:

Education:	Sexuality:	Marital Status:	Living Status:
Primary	Heterosexual	Single	Alone
Secondary	Homosexual	Married	With spouse
College	Bisexual	Divorced	With parents
Post grad	Transsexual	Widowed	Assisted living
Doctorate		Separated	Nursing home

Tobacco:	Alcohol:	Illicit Drugs:	Caffeine:
Never / Past / Active	Never / Past / Active	Never / Past / Active	Never / Past / Active
Cigarette / Cigar / Pipe	Liquor / Wine / Beer	Cocaine / Marijuana	Coffee / Tea / Soda
Snuff / Dip / Chew	____ drinks per	Heroine / Amphetamine	____cans / cups per day
Start:____ / Stop: ____	Day / Week / Month	Barbiturate / LSD / PCP	
Packs per Day: _____	AA / Alcohol Rehab	IV Drug Abuse / Drug Rehab	

Please indicate when you last had any of the following preventative tests or services:

_____ Chest X-Ray	_____ Pneumonia Vaccine	_____ PSA Blood Test (Prostate)
_____ Abdominal Aortic Aneurysm Screening (AAA Scan)	_____ Shingles Vaccine	_____ Colonoscopy
	_____ Tetanus Vaccine	_____ Mammogram
_____ EKG	_____ Hepatitis Vaccine	_____ Pap Smear
_____ Influenza Vaccine	_____ Bone Density Test	_____ Physical Exam

NOTES: _____
_____