

4. **Alternative Therapies:**

<input type="checkbox"/> Herbs	<input type="checkbox"/> Acupuncture
<input type="checkbox"/> Homeopathic	<input type="checkbox"/> Chiropractic
<input type="checkbox"/> Vitamins	<input type="checkbox"/> Massage Therapy

5. **Past Medical History** Have you ever had any of the following? (Check all that apply):

<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Myocardial Infarction (heart attack)
<input type="checkbox"/> Anemia	<input type="checkbox"/> Nerve/Muscle Disease
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Osteoporosis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Psychiatric Disorder (If yes specify) _____ _____ _____
<input type="checkbox"/> Asthma	
<input type="checkbox"/> Cancer (if Yes, specify below) _____ _____	
<input type="checkbox"/> Cataracts	
<input type="checkbox"/> CHF	
<input type="checkbox"/> Clotting Disorder	<input type="checkbox"/> Pulmonary Embolism
<input type="checkbox"/> COPD	<input type="checkbox"/> Seizure
<input type="checkbox"/> Deep Vein Thrombosis (DVT)	<input type="checkbox"/> Sickle Cell Anemia
<input type="checkbox"/> Depression	<input type="checkbox"/> Stroke
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Thyroid Disease
<input type="checkbox"/> Emphysema	<input type="checkbox"/> TIA (mini-stroke)
<input type="checkbox"/> Gerd	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Ulcers of the stomach
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Any other conditions (Specify)
<input type="checkbox"/> Heart Murmur	
<input type="checkbox"/> Hepatitis	
<input type="checkbox"/> History of Blood Transfusion	
<input type="checkbox"/> HIV/AIDS	
<input type="checkbox"/> Hyperlipidemia (Cholesterol)	
<input type="checkbox"/> Hypertension (Blood Pressure)	
<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Liver Disease	
<input type="checkbox"/> Lung Problems	
<input type="checkbox"/> Meningitis	

6. **Past Surgical History:**

Date	Surgical Procedure

7. Last Time You Had A (list a year):

	Year		Year
Flu Vaccine		Tetanus Vaccine	
Hepatitis B Vaccine		TB (Tuberculosis) Test	
Pneumonia Shot		Eye Exam	
Colonoscopy		PSA (Prostate Blood Test) (Men Only)	
Cholesterol Test		Eye Exam	
Mammogram			

8. Family History: I am adopted I do not know my family medical history

Family Member	Alive	Deceased	Alcohol abuse	Arthritis	Asthma	Birth defects	Cancer	COPD	Depression	Diabetes	Drug Abuse	Early death	Hearing loss	Heart disease	Hyperlipidemia	Hypertension	Kidney disease	Learning disabilities	Mental illness	Mental retardation	Miscarriages/ stillbirth	Stroke	Vision loss	Clotting disorder	Lung Disease	Tuberculosis
Mother																										
Father																										
Sister																										
Brother																										
Daughter																										
Son																										
Mat. Aunt																										
Uncle																										
Pat. Aunt																										
Uncle																										
Mat. Grandma																										
MGF																										
Pat. Grandma																										
PGF																										

Other significant family health problems not listed above (including Cancer Type):

9. **Social History:**

Smoking Status:	<input type="checkbox"/> Packs per day ___ for ___ years <input type="checkbox"/> Quit Smoking Y N When _____ <input type="checkbox"/> Never
Alcohol	<input type="checkbox"/> Drinks per week _____
Caffeine	<input type="checkbox"/> Cups per day _____
Illegal Drugs	<input type="checkbox"/> Type
Exercise	<input type="checkbox"/> Times per week _____
Sexually Active	Y N <input type="checkbox"/> Men <input type="checkbox"/> Women <input type="checkbox"/> Both

10. **FOR WOMEN ONLY:**

Age at onset of menstrual period:	Date of last menstrual period:
Use Birth Control? Y N	Type of Birth Control:
Number of Pregnancies:	Number of Live Births:
Number of Abortions:	Number of Miscarriages:
Year of Last:	
Breast Exam:	Results: _____
Mammogram:	Results: _____
Pap:	Results: _____

Patient Signature: _____ **Date:** _____