

	Patient Date of Birth: _____
Form completed by: _____	Date Completed: _____

As part of routine healthcare, we encourage every person over 18 to have an advance directive. To be useful, this document should name someone you trust to make decisions for you if you are ever unable to make decisions for yourself.

Do you have a healthcare Power of Attorney?     YES     NO

Do you have an advance directive?     YES     NO    If yes, please bring or mail a copy to our office.

If you do not have an advance directive, please ask your provider for additional information.

PAST MEDICAL HISTORY (include year if known)		
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Anemia	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> Peripheral Nerve Disease
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Gout	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Headache	<input type="checkbox"/> Pneumonia
<input type="checkbox"/> Asthma	<input type="checkbox"/> Head Trauma	<input type="checkbox"/> Prostate Condition
<input type="checkbox"/> Atrial Fibrillation	<input type="checkbox"/> Hearing Loss	<input type="checkbox"/> Reflux/Heartburn
<input type="checkbox"/> Back Problem	<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Seizure
<input type="checkbox"/> Bleeding Disorder	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Sinus Disease
<input type="checkbox"/> Blood Clots	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Skin Condition
<input type="checkbox"/> Bowel/Rectal Disease	<input type="checkbox"/> High Cholesterol	<input type="checkbox"/> Sleep Apnea
<input type="checkbox"/> Breathing Difficulty	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Snoring
<input type="checkbox"/> Cancer (type) _____	<input type="checkbox"/> Infectious Disease	<input type="checkbox"/> Spinal Cord Disease
<input type="checkbox"/> Cataracts	<input type="checkbox"/> Implanted Cardiac Device	<input type="checkbox"/> STD
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> Chronic Bronchitis	<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Stroke
<input type="checkbox"/> COPD	<input type="checkbox"/> Lupus	<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Coronary Heart Disease	<input type="checkbox"/> Macular Degeneration	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Depression	<input type="checkbox"/> Memory Disorder	<input type="checkbox"/> Valve Problem/Heart Murmur
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Meningitis or Encephalitis	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Drug Dependence	<input type="checkbox"/> Migraines	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Muscle Disease	
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Obesity	Last Menstrual Period: _____
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Osteoporosis	Pregnancies(#) _____ Live Births(##) _____

CURRENT MEDICATIONS/VITAMINS/HERBS/SUPPLEMENTS (please bring all medications with you)					
Name of Medication	Dose	Frequency	Name of Medication	Dose	Frequency

ALLERGIES	
Allergies to Medications	<input type="checkbox"/> Latex    Environmental/Seasonal Allergies

**What is your preferred local pharmacy?** \_\_\_\_\_

SURGERIES (include year if known)		
<input type="checkbox"/> Appendectomy	<input type="checkbox"/> Heart bypass	<input type="checkbox"/> Ovary (right/left) removed
<input type="checkbox"/> Back Surgery	<input type="checkbox"/> Hip Replacement	<input type="checkbox"/> Skin Cancer
<input type="checkbox"/> Breast Surgery	<input type="checkbox"/> Hernia	<input type="checkbox"/> Tonsillectomy
<input type="checkbox"/> C-Section	<input type="checkbox"/> Hysterectomy	<input type="checkbox"/> Tubal Ligation (BTL)
<input type="checkbox"/> Gallbladder	<input type="checkbox"/> Knee Replacement	<input type="checkbox"/> Vasectomy
<input type="checkbox"/> Other: _____	Have you ever had problems with general anesthesia? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**Have you been hospitalized in the past 12 months?**     No     Yes    **When:** \_\_\_\_\_

**Reason:** \_\_\_\_\_

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**FAMILY HISTORY**

No Knowledge of blood relative history  Adopted

Family Member	Alive/ Deceased	Age	Medical Condition
Father			<input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Other: _____
Mother			<input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Other: _____
Grandfather (Maternal)			<input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Other: _____
Grandfather (Paternal)			<input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Other: _____
Grandmother (Maternal)			<input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Other: _____
Grandmother (Paternal)			<input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Other: _____
Brother-1			<input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Other: _____
Brother-2			<input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Other: _____
Sister-1			<input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Other: _____
Sister-2			<input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Other: _____
Uncle			<input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Other: _____
Aunt			<input type="checkbox"/> Cancer: Type _____ <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Failure <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Blood Pressure <input type="checkbox"/> Asthma <input type="checkbox"/> Other: _____

**MAJOR INJURIES/FRACTURES (include year if known)**

\_\_\_\_\_

**MEDICAL TESTING (include year of most recent if known)**

<input type="checkbox"/> Mammogram	<input type="checkbox"/> Colonoscopy	<input type="checkbox"/> PSA (Prostate Cancer Screening)
<input type="checkbox"/> Pap Smear	<input type="checkbox"/> Sigmoidoscopy	<input type="checkbox"/> CT Scan
<input type="checkbox"/> Bone Density test	<input type="checkbox"/> Stool Blood Test	<input type="checkbox"/> MRI
<input type="checkbox"/> EKG	<input type="checkbox"/> Exercise Stress Test	<input type="checkbox"/> Echocardiogram
<input type="checkbox"/> X-Ray	<input type="checkbox"/> HIV Test	<input type="checkbox"/> Other: _____

**VACCINATIONS**

<input type="checkbox"/> Flu	<input type="checkbox"/> Pneumovax (Pneumonia)	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Meningitis
<input type="checkbox"/> Tetanus	<input type="checkbox"/> Zostavax (Shingles)	<input type="checkbox"/> Gardasil (HPV)	<input type="checkbox"/> Other: _____

**SOCIAL HISTORY**

With whom do you live? \_\_\_\_\_ Pets? If yes, what type? \_\_\_\_\_

Highest degree/level of education: \_\_\_\_\_

Have you traveled outside of the state or country in the past year?  No  Yes Where: \_\_\_\_\_

Which is your dominant hand?  Right  Left

Marital Status:  Single  Married  Divorced or Separated  Widowed  Partnered

Employment Status:  Employed  Unemployed  Retired  Disabled

Occupation (list previous if retired): \_\_\_\_\_

Tobacco:  Never  Smoke \_\_\_\_\_ packs/day  Chew  Former Smoker Date Quit: \_\_\_\_\_

Alcohol:  Never  Occasional  1-2 /day  More than 2/day

Recreational Drugs:  Never  Yes, what substance? \_\_\_\_\_

Exercise:  None/Occasional  1-3 days/week  3+ days/week **Daily stress level: (circle one)**  
Low 1 2 3 4 5 6 7 8 9 10 High

Communication Needs:  None  Visually Impaired  Hearing Impaired  Interpreter  Illiterate

**Is there anything about your medical or personal history that you would like your health care provider to know?**

\_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_