

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

If we need to contact you, may we call or send you a letter?  Yes  No

May we leave a message with a person ( Yes  No) or an answering machine ( Yes  No)?

**In case of an emergency, who should we contact?**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

**Allergies**

Are you allergic to any foods or medicines?  No  Yes \_\_\_\_\_

What medicines do you take now? \_\_\_\_\_

**Medical History**

Please place a plus mark (+) by any of these medical problems you have ever had. If you have not had the problem, put a minus mark (-). Tell us if your mother (M), father (F), brother or sisters (S) have had a medical problem in the second column. Tell us about the problems in the space below.

Problem	You	Problem	You	Family
Surgery		Diabetes		
Seizures/ Neurological Disease		Mental Illness, Depression		
Frequent or Severe Headaches		Sickle Cell Trait/Blood Disorder		
Eye, Ear, Nose, Throat Problems		High Cholesterol		
Bronchitis/Pneumonia/COPD		High Blood Pressure		
Anemia or Clotting Disorder		Heart Disease/Attack or Stroke		
Varicose Veins/Phlebitis/Blood Clots		Cancer		
Hepatitis/Liver Disease		Birth Defects/Mental Retardation		
Gall Bladder Disease		Tuberculosis/Positive TB Test		
Gastrointestinal Disease		Other		
Bladder or Kidney Infections		Other		
Sexually Transmitted Infections		Other		
Abnormal Pap Smear		Other		

Comments: \_\_\_\_\_  
\_\_\_\_\_

**Immunizations**

What year was your last tetanus-diphtheria vaccination? \_\_\_\_\_  I do not know

Have you had a Measles-Mumps-Rubella (MMR) vaccination?  Yes, in \_\_\_\_\_  No  I do not know

**Social History, Health and Safety Risks**

Are you:  Married  Single  Living with partner  Divorced/Separated  Spouse deceased

Do you use tobacco?  No  Yes Do you drink alcoholic beverages?  No  Yes

Have you ever been hit, threatened or abused by a partner or family member?  No  Yes

How old were you the 1<sup>st</sup> time you had sexual intercourse? \_\_\_\_\_

Do you use/do anything now for birth control (including tubal ligation or vasectomy)?  No  Yes \_\_\_\_\_

**For women:** Number of times pregnant: \_\_\_\_\_ Number of births: \_\_\_\_\_ Number of miscarriages/abortions \_\_\_\_\_

Did any infants weigh more than 9 pounds at birth?  No  Yes

Any pregnancy complications? \_\_\_\_\_

Please sign your name: \_\_\_\_\_ Today's date: \_\_\_\_\_

Interpreted/read to patient by if applicable: \_\_\_\_\_ Date: \_\_\_\_\_

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