

FAMILY HISTORY:

Adopted

Medical condition:	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather
Anxiety								
ADD/ADHD								
Alcoholism								
Allergies								
Alzheimer's disease								
Asthma								
Autoimmune disease								
Blood pressure								
Coronary artery disease								
Cancer (specify below)								
CVA (stroke)								
Depression								
Developmental delay								
Diabetes								
Eczema								
Hearing deficiency								
High blood pressure								
High cholesterol								
Irritable bowel disease								
Learning disability								
Mental illness								
Migraines								
Obesity								
Osteoarthritis								
Osteoporosis								
PVD								
Renal (kidney) disease								
Seizure disorder								

Other family history:

SURGICAL HISTORY: (list type and date):

Tobacco use:

Have you ever used tobacco? No/never Yes Have you used tobacco in the last 30 days? No Yes

Have you used smokeless tobacco in the last 30 days? No Yes

Smoking Tobacco use: No Yes

Usage per day: _____ Years used: _____ Packs per year: _____ Age started: _____ Age stopped: _____

Non-Smoking Tobacco use: No Yes

Usage per day: _____ Years used: _____ Packs per year: _____ Age started: _____ Age stopped: _____

Vaping:

Have you ever vaped? No/never Yes

What is your current vaping status? Current user Not a current user

Device type: Advanced Personal Vaporizers (APVs) Disposable E-Cigar E-Cigarette Rechargeable Other

Frequency: Daily Weekly Occasionally Other

Current strength: _____% or _mg.ML

Vaping reason: Quit smoking Socializing Other _____

Alcohol:

Do you drink alcohol? No Yes Formerly Type

of alcohol: beer liquor wine

Frequency: daily weekly monthly yearly occasionally rarely socially Amount: _____

Last drink: today last night yesterday last week two weeks ago last month last year

How many times in the past year have you had 5 or more drinks in a day? _____

Drugs:

Any drug use? No Yes If yes, what kind of drug(s)? _____

Any illegal drug use? No Yes Use of marijuana? No Yes

Caffeine:

Do you drink/consume caffeine? No Yes Caffeine per day: _____

Type of caffeine: chocolate coffee energy drinks soda tablets tea

Lifestyle:

Changes in sleep patterns: No Yes Average number of hours of sleep per night: _____

Trouble falling asleep: No Yes Difficulty staying asleep: No Yes

Frequent waking episodes at night: No Yes

Disrupted breathing, gasping, gagging, or choking for air during sleep: No Yes

Activity level: moderate sedentary vigorous Health club member: Now Previously Never

Type of exercise: _____ Exercise frequency: _____ Hours/week _____

of current sexual partners? _____ I use condoms: Always Sometimes Never

Animals in the home: No Yes Birds Dogs Rodents Cats Reptiles Other _____

Do you clean up after the animals? No Yes

Do you have a religious affiliation? No Yes

Do you practice your religion? No Yes

Is religion/spirituality an important part of your life? No Yes

Do you have spiritual beliefs? No Yes

Do you agree to blood/blood products? No Yes

Women Only - Menstrual/Pregnancy History:

How old were you when you had your 1st menstrual period? _____

1st day of last menstrual period? _____

Are your menses regular (every 21-35 days) or irregular? Regular Irregular

How often do they come? _____

Is the flow: Heavy Normal Light

Do you have cramps? No Yes

Do you have bleeding between your menstrual periods? No Yes

Are you using a method to avoid pregnancy? No Yes. If so, what method do you use? _____

Are you trying to achieve pregnancy? No Yes

How many times have you been pregnancy? _____

Any breast concerns like nipple discharge, lumps or pain? No Yes

Do you do breast checks on yourself at home? No Yes

Last Mammogram? Date: _____ Last Pap Smear? Date: _____

Medication Reconciliation

(Including vitamins, supplements and herbs)

<u>Name of Medication:</u>	<u>Dose:</u> (example: 100mcg, 10mg, etc.)	<u>Frequency:</u> (example: once a day, before meals, etc.)

Preferred pharmacy: _____

MAIL ORDER PHARMACY: _____

Allergies

(Medical, seasonal, food)

<u>Name:</u>	<u>Describe your reaction:</u>

LAST TIME YOU HAD THE FOLLOWING (Please list year)

FLU VACCINE _____	CHOLESTEROL TEST _____	EYE EXAM _____
COVID VACCINE _____	COLONOSCOPY _____	DENTAL EXAM _____
PNEUMONIA VACCINE _____	RECTAL EXAM _____	PSA (men only) _____
HEPATITIS VACCINE _____	BONE DENSITY TEST _____	
MMR VACCINE _____	STOOL BLOOD EXAM _____	
TETANUS VACCINE _____		