Name:_____ Date:_____

Allergies:_____ Nature of Reaction_____

Medical Problems:_____

Previous Surgery:_____

Current Medications /Supplements:_____

Previous Hospitalizations:_____

Significant Injuries, ER care, Transfusions, Childhood diseases, Dental issues:_____

Year of last Tetanus Vaccine:_____

Other Vaccinations needed:_____ Last Flu/pneumonia vaccine:_____

Last Physical Exam:_____ Last gynecologic Care (females):_____

Last ECG/Heart testing:_____ Last Mammogram:_____

Last Colonoscopy:_____ Last PSA (males):_____

Last eye exam:_____ Any Transfusions received:_____

Family History :-----Please list their age or birth year, status (alive or deceased),and any major health problems------

Father:_____

Mother:_____

Siblings:_____

Children:_____

Paternal Grandfather:_____

Paternal Grandmother:_____

Maternal Grandfather:_____

Maternal Grandmother:_____

Grandchildren (if applicable):_____

Spouse (if applicable):_____

Other relatives with significant Health Issues:_____

Lifestyle Issues: Include years used, year discontinued, and specific daily use if indicated.

Smoking/Tobacco use:_____

Caffeine Use:_____

Alcohol Use:_____

Recreational Drug Use:_____

Exercise Routine:_____