

Childhood**Birthweight:**

ADD or ADHD	no	yes
asthma	no	yes
born premature	no	yes
developmental delay or autism	no	yes
chicken pox	no	yes
rheumatic fever	no	yes
measles	no	yes
other childhood illnesses - please list:		

Medical Conditions - Patient

acid reflux or heartburn	no	yes
alcohol or drug addiction	no	yes
allergies/sinus problems	no	yes
arthritis- osteoarthritis	no	yes
arthritis- rheumatoid	no	yes
asthma	no	yes
atopic dermatitis or eczema	no	yes
back pain or sciatica	no	yes
bleeding problem or hemophilia	no	yes
blood clots, DVT or pulmonary embolus	no	yes
cancer- breast	no	yes
cancer- colon/intestine	no	yes
cancer- lung	no	yes
cancer- other	no	yes
cancer- prostate	no	yes
colitis	no	yes
COPD, chronic bronchitis/emphysema	no	yes
depression or anxiety	no	yes
diabetes- type 1	no	yes date:
diabetes- type 2	no	yes date:
glaucoma	no	yes
heart attack	no	yes
heart pain or angina	no	yes date:
heart failure	no	yes
heart murmur	no	yes

Circle yes or no for each**Family Medical History****Asthma**

mother	father	brother	sister	grandmother
grandfather	son	daughter		

Diabetes

mother	father	brother	sister	grandmother
grandfather	son	daughter		

Heart Attack

mother	father	brother	sister	grandmother
grandfather	son	daughter		
Age at first heart attack:				

Heart Disease

mother	father	brother	sister	grandmother
grandfather	son	daughter		

High Cholesterol

mother	father	brother	sister	grandmother
grandfather	son	daughter		

High Blood Pressure

mother	father	brother	sister	grandmother
grandfather	son	daughter		

Stroke

mother	father	brother	sister	grandmother
grandfather	son	daughter		

Thyroid Disease

mother	father	brother	sister	grandmother
grandfather	son	daughter		

Depression

mother	father	brother	sister	grandmother
grandfather	son	daughter		

Other mental illness:(list)

mother	father	brother	sister	grandmother
grandfather	son	daughter		

Breast Cancer

mother	father	brother	sister	grandmother
grandfather	son	daughter		

heart valve problem	no	yes
high blood pressure	no	yes
high cholesterol	no	yes
irritable bowel syndrome	no	yes
kidney stones	no	yes
liver disease or cirrhosis	no	yes
migraine headache	no	yes
seizure disorder or epilepsy	no	yes
sexually transmitted disease	no	yes
stroke- ischemic (not bleeding)	no	yes
stroke-hemorrhagic (bleeding)	no	yes
urinary incontinence	no	yes
urinary tract infections	no	yes
thyroid problem	no	yes

OTHER:

Hospitalizations- Please list

Reason	Date	Reason	Date
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Colon Cancer

mother father brother sister grandmother
grandfather son daughter

Melanoma

mother father brother sister grandmother
grandfather son daughter

Ovarian Cancer

mother father brother sister grandmother
grandfather son daughter

Prostate Cancer

mother father brother sister grandmother
grandfather son daughter

Other Cancer: (list)

mother father brother sister grandmother
grandfather son daughter

WOMEN ONLY Pregnancy

Have you ever been pregnant?	no	yes
Number of pregnancies		
Number of full term births		
Number of premature births (< 37 wks)		
Number of miscarriages or abortions		
Number of children born (total)		
Number of C-sections		
Childbirth complications?	no	yes

describe complications:

WOMEN ONLY Gynecologic Problems

abnormal Pap smear	no	yes
uterine fibroids	no	yes

irregular periods	no	yes	
endometriosis	no	yes	
polycystic ovaries	no	yes	
infertility	no	yes	
pelvic inflammatory disease	no	yes	
sexually transmitted disease	no	yes	describe infection:
other:			

Surgeries

appendectomy	no	yes	
skin biopsy	no	yes	
cholecystectomy (gallbladder)	no	yes	
hernia repair	no	yes	what kind/where? _____
hysterectomy (uterus only)	no	yes	
hysterectomy BSO (uterus and ovaries)	no	yes	
spinal surgery	no	yes	
tubal ligation	no	yes	
tonsillectomy	no	yes	
tympanostomy (ear) tubes	no	yes	
wisdom teeth	no	yes	
other surgeries:	no	yes	

Immunizations- Adults

Year of last Tetanus booster shot: _____

Hepatitis A (two shot series)	no	yes
Hepatitis B (three shot series)	no	yes
MMR/measles	no	yes
pneumonia/PneumoVax	no	yes
tuberculosis test (PPD)	no	yes

For Children, please bring shot record

Health Maintenance

For Men:

Date of last complete physical	_____
Date of last cholesterol check	_____
Date of last PSA level	_____
Date of last colonoscopy	_____

For Women:

Date of last complete physical	_____
Date of last Pap smear	_____
Date of last cholesterol check	_____
Date of last mammogram	_____

penicillin	no	yes
latex	no	yes
sulpha	no	yes
other	no	yes