Patient History

Name:_____ Birthdate: ____/____/_____ Date:___/___/____

Do you have.... Please check ✓ all that apply.

___Alcoholism
___Anemia
___Angina/Heart Attack
___Arthritis
___Asthma/Hay Fever
___Birth Defects
___Bladder Disease
___Bleeding Disorder
___Cancer_____
___Other_____
___Dizziness
___Emphysema
___Epilepsy/Seizures
___Glaucoma
___Headaches
___Hearing Loss
___Heart Failure
___Kidney Disease
___Diabetes
___Lung Problems
___Mental Illness
___Stroke
___Thyroid Problems
___Tinnitus/Noises in ears
___Tuberculosis
___Venereal Disease
___Other
___Liver Problems

If Under 18 Years

___Mom's Pregnancy Complications at Birth
___Complications
___Childhood Disease
___Birth Defects

Drug Allergies?_____
Current Medications?_____
Surgeries or Injuries?_____

Family History

Has anyone is in your family had (Please check ✓ all that apply)?

___Alcoholism
___Anemia
___Angina/Heart Attack
___Arthritis
___Asthma/Hay Fever
___Birth Defects
___Bladder Disease
___Bleeding Disorder
___Diabetes
___Other Problems_____
___Dizziness
___Emphysema
___Epilepsy/Seizures
___Glaucoma
___Headaches
___Hearing Loss
___Heart Failure
___High Blood Pressure
___Liver
___Lung Problems
___Mental Illness
___Stroke
___Thyroid Problems
___Tinnitus/Noises in ears
___Tuberculosis
___Venereal Disease
___Kidney Disease
___Cancer:_____

Social History

(Please check ✓all that apply.) Do you.....

____Exercise
Type:_____
How often:_____

_____Use Alcohol
Beer/ Wine/ Liquor
How Often:_____

_____ Use Tobacco
Cigarettes/ Cigars/Pipe
Snuff/Chew Tobacco

____Use Drugs
Marijuana/Heroin
Cocaine/LSD/Crack

Immunization History

Please check ✓ yes or no.

Tetanus-Past 10 years	No ( )	Yes ( )
MMR	No ( )	Yes ( )
Hepatitis A	No ( )	Yes ( )
Hepatitis B	No ( )	Yes ( )
Pneumonia	No ( )	Yes ( )
Flu Vaccine- Past year	No ( )	Yes ( )
Meningitis	No ( )	Yes ( )
TB Skin Test	No ( )	Yes ( )

_____ _____
Patient Signature Date