



**IMMUNIZATIONS:** Date of most recent record.

Hepatitis A \_\_\_\_\_ Hepatitis B \_\_\_\_\_ Influenza (flu shot) \_\_\_\_\_ MMR \_\_\_\_\_ Pneumovax (pneumonia) \_\_\_\_\_  
Meningitis \_\_\_\_\_ Tetanus (Td) \_\_\_\_\_ Varicella (chicken pox) shot or illness \_\_\_\_\_ Tdap (tetanus & pertussis) \_\_\_\_\_

**HEALTH MAINTENANCE:** Date of most recent record.

Cholesterol \_\_\_\_\_ Abnormal?  Yes  No  
Colonscopy \_\_\_\_\_ Abnormal?  Yes  No  
Bone Density Scan \_\_\_\_\_ Abnormal?  Yes  No  
Women: Mamogram \_\_\_\_\_ Abnormal?  Yes  No Pap Smear \_\_\_\_\_ Abnormal?  Yes  No  
Men: PSA (prostate) \_\_\_\_\_ Abnormal?  Yes  No

**MEDICAL HISTORY:**

**SURGICAL HISTORY:**

Major Illnesses: (i.e. high blood pressure, high cholesterol, depression, etc.)	Year of Diagnosis	Currently Treated?	Surgeries:	Year of Surgery	Reason for Surgery
1			1		
2			2		
3			3		
4			4		
5			5		
6			6		
7			7		
8			8		

**FAMILY HISTORY:** Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____	High cholesterol _____
Cancer, specify type _____	High blood pressure _____
Heart disease _____	Stroke _____
Depression/suicide _____	Bleeding/clotting disorder _____
Genetic disorders _____	Asthma/COPD _____
Diabetes _____	Anxiety _____
Kidney disease _____	Other: _____

**SOCIAL HISTORY:**

**Tobacco Use**

Cigarettes  Never  Quit Date \_\_\_\_\_  
 Current Smoker: packs/day \_\_\_\_\_ # of yrs \_\_\_\_\_  
Other Tobacco:  Pipe  Cigar  Snuff  Chew  
Are you interested in quitting?  Yes  No

**Alcohol Use**

Do you drink alcohol?  Yes  No # drinks/week \_\_\_\_\_  
Is your alcohol use a concern for you or others?  Yes  No

**Drug Use**

Do you use any recreational drugs?  Yes  No  
Have you ever used needles to inject drugs?  Yes  No

**Sexual Activity**

Sexually active:  Yes  No  Not currently  
Current sex partner(s) is/are:  male  female  
Birth control method: \_\_\_\_\_  None needed  
Have you ever had any sexually transmitted diseases (STDs)?  
 Yes  No

Are you interested in being screened for sexually transmitted diseases?  Yes  No

**Caffeine Intake:**  None  Coffee/tea/soda \_\_\_\_\_ cups/day

**Weight:** Are you satisfied with your weight?  Yes  No

**Diet:** How do you rate your diet?  Good  Fair  Poor

Do you eat or drink four servings of dairy or soy daily or take calcium supplements?  Yes  No

**Exercise:** Do you exercise regularly?  Yes  No

What kind of exercise? \_\_\_\_\_

How long (minutes) \_\_\_\_\_ How often? \_\_\_\_\_

If you do not exercise, why? \_\_\_\_\_

**SOCIOECONOMICS:**

Occupation: \_\_\_\_\_

Employer: \_\_\_\_\_

Martial Status:  Single  Partner/Married  Divorced

Widowed  Other: \_\_\_\_\_

Number of children/ages: \_\_\_\_\_

**WOMENS HEALTH HISTORY**

# Pregnancies: \_\_\_\_\_

# Deliveries: \_\_\_\_\_

# Abortions: \_\_\_\_\_

# Miscarriages: \_\_\_\_\_

Age at start of periods: \_\_\_\_\_ Age at end of periods: \_\_\_\_\_