

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC.? _____ LIST _____

DRUG ALLERGY _____ NAME OF MEDICATION(S) _____

REACTION _____

DO YOU USE TOBACCO NOW? _____ IN THE PAST? _____ TYPE & DAILY AMOUNT _____ HOW LONG? _____

DO YOU USE ALCOHOLIC BEVERAGES? _____ TYPE _____ WEEKLY AMOUNT _____ HOW LONG? _____

DO YOU USE STREET DRUGS NOW? _____ IN THE PAST ? _____ TYPE _____ HOW OFTEN? _____

PLEASE CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED

SMALLPOX _____ TETANUS _____ TYPHOID _____ POLIO _____ INFLUENZA _____

PREVIOUS OPERATIONS: PLEASE LIST GIVING DATES, HOSPITAL WHERE PERFORMED & NAME OF SURGEON _____

PREVIOUS X-RAY THERAPY OR SIMILAR THERATMENT: _____

MEDICATIONS USING CURRENTLY:

NAME OF MEDICINE	DOSAGE	HOW OFTEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

MEDICATION USED IN THE PAST: _____

HAVE YOU TAKEN OVER THE COUNTER ANTI-INFLAMMATORIES (IBUPROFEN, MOTRIN, ADVIL)? _____

LAST PAP SMEAR _____ LAST MAMMOGRAM _____ LAST PROSTRATE EXAM _____

MENSTRUAL HISTORY: LAST PERIOD _____ PERIODS ARE: _____ REGULAR _____ IRREGULAR

NUMBER OF PREGNANCIES _____ NUMBER OF MISCARRIAGES _____

HAVE YOU TAKEN CORTISONE TYPE DRUGS? _____ ORAL CONTRACEPTIVES? _____

HAVE YOU RECEIVED A BLOOD TRANSFUSION? _____ DATE: _____

RECENT HISTORY OF WEIGHT LOSS? _____ HOW MANY POUNDS ? _____ HOW LONG? _____

PLEASE WRITE THE REASON(S) YOU CAME TO THE DOCTOR AT THIS TIME _____

WHAT IS YOUR MAIN MEDICAL PROBLEM & HOW LONG HAVE YOU HAD IT? _____

WHAT IS YOUR MAIN SYMPTOM? (FOR EXAMPLE: PAIN IN CHEST, SHORTNESS OF BREATH) _____

REVIEWED _____ DATE _____
PHYSICIAN

FORMATION FOR YOUR PHYSIC

PLEASE ANSWER THE FOLLOWING QUESTION AND BRING THIS RECORD TO YOUR FIRST EXAMINATION. IT WILL HELP YOUR PHYSICIAN TO KNOW NOT ONLY ABOUT YOUR HEALTH, BUT ALSO ABOUT YOUR FAMILY AND RELATIVES.

DATE _____

YOUR FULL NAME _____ M _____ F _____ TELEPHONE NUMBER _____

DATE OF BIRTH _____ PLACE OF BIRTH _____ RACE/NATIONALITY OF PARENTS _____

RELIGION _____ EDUCATION _____ AGE ON COMPLETION _____
(HIGHEST LEVEL ATTAINED)

OCCUPATION _____ HOW LONG? _____

WHERE & WHEN HAVE YOU LIVED OR TRAVELED OUTSIDE OF THE U.S.& CANADA _____

	LIVING	AGE/AGE AT DEATH	PRESENT HEALTH OR CAUSE OF DEATHE
FATHER	YES ___ NO ___	_____	_____
MOTHER	YES ___ NO ___	_____	_____
SPOUSE	YES ___ NO ___	_____	_____

PRESENT MARRIAGE YEAR _____ PREVIOUS MARRIAGE-YEAR & DURATION _____

BROTHERS-NO.LIVING _____ HEALTH _____

NO DEAD _____ CAUSE OF HEALTH _____

SISTER NO LIVING _____ HEALTH _____

NO DEAD _____ CAUSE OF HEALTH _____

CHILDREN LIVING _____ AGES AND HEALTH _____

CHILDREN DEAD _____ AGES AND HEALTH _____

PLEASE CIRCLE ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

ALCOHOLISM	CANCER	HEART DISEASE	NERVOUS ILLNESS
ALLERGY	DIABETES	HIGH BLOOD PRESSURE	STROKE
BLEEDING TENDENCY	EPILEPSY	KIDNEY DISEASE	TUBERCULOSIS

PLEASE CIRCLE ILLNESSES OR CONDITIONA (S) YOU HAVE HAD

ANEMIA	GLAUCOMA	KIDNEY DISEASE	RHEUMATIC FEVER
ARTHRITIS	GONORRHEA	KIDNEY STONES	STREP INFECTION
ASTHMA	HEART TROUBLE	LUPUS	SYPHILIS
BLEEDING TENDENCIES	HEPATITIS	NEUROLOGIC DISORDER	TUBERCULOSIS
CANCER	HIV	PEPTIC ULCER	UTI
DIABETES	HYPERTENSION	PNEUMONIA	VEIN TROUBLE
DIABETES, INSULIN TAKING	JAUNDICE	PSYCHIATIRC DISORDER	

PLEASE LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED
