

Medication List

- 1. _____ 6. _____
- 2. _____ 7. _____
- 3. _____ 8. _____
- 4. _____ 9. _____
- 5. _____ 10. _____

Allergies

Please list your allergies: _____

Immunizations

When was your last . . . ? Tetanus Shot _____ Pnuemovax: _____ Flu Shot: _____

Family History

What illnesses run in your family? Who is affected?

- ___ Diabetes Mellitus ___ Mother ___ Father ___ Brother ___ Sister
- ___ Heart Disease ___ Mother ___ Father ___ Brother ___ Sister
- ___ High Blood Pressure ___ Mother ___ Father ___ Brother ___ Sister
- ___ Colon Cancer ___ Mother ___ Father ___ Brother ___ Sister
- ___ Breast Cancer ___ Mother ___ Sister
- ___ Prostate Cancer ___ Father ___ Brother
- ___ High Cholesterol ___ Mother ___ Father ___ Brother ___ Sister
- ___ Other _____

Social History

- Do you smoke? ___no ___yes If yes, how much do you smoke? _____
- Do you drink? ___no ___yes If yes, how much do you drink? _____
- Do you use illicit drugs? ___no ___yes If yes, what drugs do you use? _____
- Are you ___married ? ___single? ___widow/widower ? Occupation: _____