

**HEALTH SUMMARY**

Patient's Name (PLEASE PRINT): \_\_\_\_\_ Date: \_\_\_\_\_

**ALLERGIES** NONE: \_\_\_\_\_


**MEDICATIONS** NONE: \_\_\_\_\_

What medications are you taking (including Birth Control Pills, Herbals, Vitamins, Dietary Supplements and Over the Counter?)


**PRESENT HEALTH CONDITIONS**

YES	NO	DISEASE	YES	NO	DISEASE
		Irregular Heart Beat			Prostate Problems
		Congestive Heart Failure			Gout
		Heart Attack			Arthritis
		Heart Murmur			Skin Disease, Type:
		Rheumatic Fever			Stroke
		High Cholesterol			Epilepsy / Seizures
		High Blood Pressure			Diabetes / High Blood Sugar
		Asthma			Thyroid Problems – too high or too low
		Emphysema / Chronic Bronchitis			Anemia / Low Blood
		Blood Clot in Lung			Bleeding Problems, Type:
		Blood Clot in Leg			Blood Transfusion
		Tuberculosis			Cancer, Type:
		Gallstones			Anxiety
		Liver Disease, Type:			Depression
		Ulcers in Bowels / Stomach			Glaucoma
		Bleeding from Bowels			Other:
		Kidney Disease, Type:			
		Kidney Stones			

**SURGERIES**

YES	NO	SURGERY	YES	NO	SURGERY
		Cataract Surgery, Left Right			Joint Replacement of knee / hip
		Tonsils Removed			Back Disc Surgery
		Neck Artery Surgery			Prostate Surgery
		Open Heart Surgery / Catheterization			Hernia Surgery
		Appendectomy			Vasectomy
		Gallbladder Removal			Hysterectomy
		Abdominal Surgery			Other:
		Broken Bone Repair			
		Joint Scope Surgery			

**FAMILY HISTORY**

YES	NO	DISEASE	RELATIONSHIP TO YOU	YES	NO	DISEASE	RELATIONSHIP TO YOU
		Heart Attack				Bleeding Problems	
		High Blood Pressure				Sickle Cell Anemia	
		High Cholesterol				Diabetes/High Blood Sugar	
		Asthma				Thyroid Problems	
		Tuberculosis				Cancer, Type:	
		Liver Disease				Cancer, Type:	
		Kidney Disease				Alcohol Abuse	
		Gout / Arthritis				Anxiety or Depression	
		Osteoporosis				Glaucoma	
		Stroke				Other:	
		Epilepsy / Seizures					

**OTHER HISTORY**

Exercise:  Never  Rarely  Other: \_\_\_\_\_

When was your last: Tetanus: \_\_\_\_\_, (Never) \_\_\_ / Hepatitis B: \_\_\_\_\_, (Never) \_\_\_ / Pneumovax: \_\_\_\_\_ (Never) \_\_\_  
 Flu Shot: \_\_\_\_\_ (Never) \_\_\_

**Smoking:**

Have you ever smoked:  Yes  No How many years did you smoke? \_\_\_\_\_ When did you quit? \_\_\_\_\_  
 How many packs per day do you smoke now? \_\_\_\_\_ Do you use smokeless tobacco:  Yes  No

**The following questions are very important and strictly confidential. Please answer them accurately.**

**Alcohol / Drugs:**

Yes  No Do you drink? How much? \_\_\_\_\_ How often? \_\_\_\_\_  
 Yes  No Do you use drugs? How much? \_\_\_\_\_ How often? \_\_\_\_\_ What kind? \_\_\_\_\_

What drugs have you used in the past? \_\_\_\_\_

**FEMALE PATIENTS ONLY**

Number of Pregnancies \_\_\_\_\_ Number of Deliveries \_\_\_\_\_ Number of Elective Abortions \_\_\_\_\_ Number of Miscarriages \_\_\_\_\_

When was your last menstruation? \_\_\_\_\_ How old were you when you went through Menopause? \_\_\_\_\_

When was your last PAP smear? \_\_\_\_\_ Have you ever had an abnormal PAP smear?  Yes  No

If "Yes", when was the abnormal PAP smear? \_\_\_\_\_

What was the abnormality? \_\_\_\_\_

What kind of treatment did you have? \_\_\_\_\_

When was your last Mammogram? \_\_\_\_\_ Have you ever had an abnormal Mammogram?  Yes  No

If "Yes", when was the Mammogram? \_\_\_\_\_

The above information is current and correct to the best of my knowledge.

I have reviewed the above history

\_\_\_\_\_  
 Patient / Guardian Signature

\_\_\_\_\_  
 Date

\_\_\_\_\_  
 Physician's Initial

\_\_\_\_\_  
 Date

01/01/2004