

Confidential Record: Information contained here will not be released unless you have authorized us to do so. Please answer all questions to the best of your knowledge.

Health Information as of _____ (enter today's date)
 (Please Print Legibly & Fill In or Correct All Fields)

Name: _____ Current Physician(s): _____

Age: _____ Height: _____ Feet _____ Inches Weight: _____ Lbs.

Reason for visit: _____

List ALL allergies (include reactions)

List your current medications (include dosages)

Do you have or have you had any of the following: (circle for each, give date occurred if Yes)

Anemia	No	Yes	Fever Blisters	No	Yes	Kidney Disease	No	Yes
Asthma	No	Yes	Goiter / Thyroid	No	Yes	Lung Disease	No	Yes
Blood Clot	No	Yes	Hay Fever / Allergies	No	Yes	Mitral Valve Prolapse	No	Yes
Cancer	No	Yes	Headaches / Migraine	No	Yes	Pulmonary Embolism	No	Yes
Depression	No	Yes	Heart Trouble	No	Yes	Skin Cancer	No	Yes
Diabetics	No	Yes	Hepatitis/Liver disease	No	Yes	Stomach Intestinal Disease	No	Yes
Epilepsy	No	Yes	High Blood Pressure	No	Yes	Stroke	No	Yes

Do you smoke? No Yes If yes, how much? _____ Pack(s)/day How long? _____

Do you take aspirin? No Yes If yes, what dose? _____ How often? _____

Number of Pregnancies _____ Living Children _____ Miscarriages _____ Abortions _____

Last menstrual period _____

Last Mammogram _____

Do you have bleeding or bruising problems? No Yes If yes, describe: _____

Do you have problems with scarring? No Yes If yes, describe: _____

Do you have any history of problems with anesthesia? No Yes If yes, describe: _____

List any medical conditions NOT listed above

List any past surgeries / hospitalizations (include dates)

Family History:

Member	Age	Living	Dead	Cause of Death	Major diseases
Father					
Mother					
Sisters					
Brothers					

Please answer the following questions regarding your health:

- 1) Have you had recent fevers or chills?.....Yes No
- 2) Have you had a significant change in weight?..... Yes No
Increase or Decrease? (circle one) How much? _____
- 3) Do you get tightness, pressure, or squeezing in your chest?..... Yes No
- 4) Do you chest pain or difficulty breathing? (circle one)..... Yes No
- 5) Do you have diarrhea, nausea or vomiting? (circle one)..... Yes No
- 6) Do you have burning with urination?.....Yes No
- 7) Have you had a skin cancer before?.....Yes No
- 8) Have you had or do you have a breast lump?.....Yes No
- 9) Do you perform a regular breast self-examination?..... Yes No
- 10) When was your last mammogram?.....Yes No
- 11) Have you ever had a problem with bleeding or blood clotting?..... Yes No
- 12) Has anyone in your family had bleeding tendencies or hemophilia?..... Yes No

Please list any additional information you feel is pertinent to your care: _____

The above information is accurate and complete to the best of my knowledge.

Signature _____ **Date** _____

