MEDICAL HISTORY

Please fill in your answers. If your response is yes to any question, please write when (year) the problem started.

Personal History

- Please indicate if you are: O Single O Married O Widowed O Divorced
- Who do you live with? O Spouse O Child O Nursing Home O Alone
- Are you working? O Yes O No If no, please move on to Past Medical History.
- At work are you exposed to any of the following? O Fume O Dust O Other Solvents O None
- Have you lost any time from work due to your health issues? O Yes O No

Current Medication List:

Medication Name	Strength	Frequency	Start Date

Do you have any medication allergies? O Yes O No
If yes, please list _____

Past Medical History O Yes O No (If no, then skip to next section)

- Do you have Asthma? O Yes O No ;if yes date diagnosed _____
- Do you have Arthritis? O Yes O No ;if yes date diagnosed _____
    - Do you have any blood disorder? O Yes O No ;if yes date diagnosed _____
    - Have you ever had a blood transfusion? O Yes O No ;if yes please list date_____
    - Have you ever had chicken pox? O Yes O No ;if yes date diagnosed _____
    - Have you ever had Congenital Abnormalities? O Yes O No ;if yes date diagnosed _____
    - Do you have diabetes? O Yes O No ;if yes date diagnosed _____
    - Have you ever had gastric problems? O Yes O No ;if yes date diagnosed _____
    - Have you ever had heart problems? O Yes O No ;if yes date

diagnosed _____

- Do you have high blood pressure? O Yes O No ;if yes date diagnosed _____
- Do you have high cholesterol? O Yes O No ;if yes date diagnosed _____
- Do you have Kidney disease? O Yes O No ;if yes date diagnosed _____
- Do you have liver disease? O Yes O No ;if yes date diagnosed _____
- Have you ever had Measles, Mumps/Rubella? O Yes O No ;if yes date diagnosed _____
- Do you have Thyroid problems? O Yes O No ;if yes date diagnosed _____
- Have you ever had tuberculosis? O Yes O No ;if yes date diagnosed _____
- Do you have any serious/incurable disease? O Yes O No ;if yes date diagnosed _____
- Do you have Cancer? O Yes O No ;if yes date diagnosed _____

If yes, please list type(s) _____

Past Medical History Cont'd

19. Have you ever had any hospitalization O Yes
O No If yes, please list dates _____
20. Have you ever been in a motor vehicle accident? O Yes
O No If yes, please list dates
_____
21. Have you ever had head injuries/ knocked unconscious? O Yes
O No If yes, please list dates _____
22. Do you have ADHD/ADD O Yes
O No
If yes, date diagnosed _____

Surgical/Procedure History

Have you ever had any surgeries/procedures done? O Yes
O No
If yes, please specify and list
dates_____

Family History

- Is your father alive? O Yes O No Year born: _____
- Does your father have/had?
  O Diabetes O Heart Problems O High BP O Stroke O TB O Cancer O None
- Is your mother alive? O Yes O No Year born: _____
- Does you mother have/had?
  O Diabetes O Heart Problems O High BP O Stroke O TB O Cancer O None
- Do you have siblings? O Yes O No If yes, how many? ( ) Brothers ( ) Sisters
- Does your sibling (s) have?
  O Diabetes O Heart Problems O High BP O Stroke O TB O Cancer O None
- Does your spouse have?
  O Diabetes O Heart Problems O High BP O Stroke O TB O Cancer O None
- Do you have children?O Yes O No If yes, how many? ( ) Sons ( ) Daughters
- Do your child/children have/had?
  O Diabetes O Heart Problems O High BP O Stroke O TB O Cancer O None

Immunizations

- Do/Did you have/had Pneumonia vaccine? O Yes O No ;if yes date taken _____
- Do/Did you have/had Flu vaccine? O Yes O No ;if yes date taken _____
- Do/Did you have/had Tetanus vaccine? O Yes O No ;if yes date taken _____
- Do/Did you have/had MMR vaccine? O Yes O No ;if yes date taken _____
- Do/Did you have/had Hep A vaccine? O Yes O No ;if yes date taken_____
- Do/Did you have/had Hep B vaccine? O Yes O No ;if yes date taken _____
- Do/Did you have/had Varicella (Chicken Pox) shot? O Yes O No ;if yes date taken _____
- Do/Did you have TB test? O Yes O No ;if yes date taken _____

If the TB test was positive, was chest X-ray done? O Yes O No ;if yes date taken _____

Social History

- Are you sexually active? O Yes O No O Never If never, move on to question 7
- At what age did you become sexually active? _____
- How many sexual partners have you had? _____
- Do you have any sexual problems? O Yes O No
- Have you ever had a sexually transmitted disease? O Yes O No
- Which sexually transmitted disease have you had?
  O Chlamydia O Gonorrhea O Herpes O Syphilis O Other _____
- Do you drink alcoholic beverages? O Yes O No
- How often do you drink alcoholic beverages? _____
- Do you drink caffeinated drinks? O Yes O No if yes, how many cups a day _____?
- Are you a smoker? O Current O Former O Never
  If you are/were a smoker, how many pack of cigarettes a day? _____ Yrs smoked _____
- Do you use or have you used any types of recreational drugs? O Yes O No

  If, yes what kind _____, when discontinued _____.

Women Only

- Date of last menstrual cycle? _____
- If stopped due to menopause and / or hysterectomy, what year stopped? _____
- Are you pregnant or is there a possibility that you are pregnant? O Yes O No
- If you are pregnant when is your expected due date? _____
- How many times have you been pregnant? _____
- How many miscarriages have you had? _____
- Previous delivery(s) was it O Vaginal or O C-section; years of delivery _____
- When was your last Pap test? _____ Was it O Normal or O Abnormal?
- Are you on any hormone replacement therapy? O Yes O No
- If female, have you had a hysterectomy? O Yes O No ;if yes date _____
- If yes, O Complete O Partial

Women over 40 years old

1. Have you had a mammogram? O Yes O No If yes, when was it done? _____
- Was it O Normal or O Abnormal? Facility done at: _____
2. Have you had a bone density? O Yes O No If yes, when was it done? _____
- Was it O Normal O Osteopenia O Osteoporosis?
3. Are you? O Menopausal O Pre-menopausal O Post menopausal

Women over 50 years old

1. When was your last Insure/FOBT (Fecal Occult Blood Test)? _____
2. Have you had Colonoscopy in the past? O Yes O No If yes, when? _____

Men over 50 years old

1. When was your last PSA (Prostate Cancer Screening) test? _____
2. When was your last Insure/FOBT (Fecal Occult Blood Test)? _____
3. Have you had Colonoscopy in the past? O Yes O No If yes, when? _____
4. If male, have you had a vasectomy? O Yes O No ;if yes date _____