
Past Medical History and Immediate Family History

(i.e. parents, grandparents, siblings)

	Self		Family Member		
	Yes	No	Yes	No	
I was adopted					Which:
Asthma					Which:
Irregular Heartbeat					Which:
Anemia					Which:
Anxiety					Which:
Autoimmune Disorder					Which:
Blood Transfusions					Which:
COPD					Which:
Breast Disease					Which:
Cancer					Which:
Coronary Artery Disease					Which:
Crohn's Disease					Which:
Cirrhosis					Which:
Hepatitis A					Which:
Hepatitis B					Which:
Hepatitis C					Which:
Heart Attack (MI)					Which:
Arthritis (<i>Osteoarthritis</i>)					Which:
Osteopenia (<i>thin bones</i>)					Which:
Osteoporosis					Which:
Varicose Veins					Which:
Difficulty Sleeping					Which:

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	Self		Family Member		
	Yes	No	Yes	No	
Depression					Which:
Diabetes					Which:
Type I (Juvenile Onset)					Which:
Type II (Adult Onset)					Which:
Gestational Diabetes					Which:
Diverticulosis					Which:
Blood Clot (DVT/PE)					Which:
Heartburn (Acid Reflux/GERD)					Which:
Kidney Disease					Which:
Kidney Stones					Which:
Stroke/TIA					Which:
Clotting Disorder					Which:
Congenital Heart Disease					Which:
Cystic Fibrosis					Which:
Dementia					Which:
Hemachromatosis					Which:
High Cholesterol					Which:
High Blood Pressure					Which:
Irritable Bowel Syndrome					Which:
Mental Retardation					Which:
Peripheral Vascular Disease					Which:
Sexually Transmitted Disease					Which:
Infertility Problems					Which:
HIV/AIDS					Which:
Peptic Ulcer Disease					Which:

Past Surgical History (*please list any surgeries that you had in the past, including dates*):

Current Prescribed Medications (*list all medications that you are currently taking prescribed by a physician, include dosage and how often taken*):

List any of the following that you currently take:

Over-the-counter medications (aspirin, Tylenol, stool softeners, Phazyme, etc.)

Herbal remedies/supplements (black cohosh, hoodia, etc.)

Vitamin/mineral supplements (Os-Cal, Vitamin C with rosehips, etc.)

Do you take any herbal supplements as medication (St. John's Wort, soy, licorice, etc.)? If yes, please list.

Fen-phen or any other diet pills	yes	no	when and for how long:
Hormone replacement therapy	yes	no	when and for how long:

Are you allergic to any of the following (*if yes please explain the reaction you had*) (List)

Food	yes	no
Medications	yes	no
Bee stings	yes	no
Shellfish/Iodine	yes	no

Do you use tobacco products?	never	currently	used to but quit < 10 years ago date:
			quit >10 years ago date:
	second-hand smoking		

If currently smoking cigarettes:	packs per day
If currently smoking cigars:	pieces per week
If currently using smokeless tobacco:	packs per day

Do you ever drink alcohol?	yes	no				
Average drinks per day (<i>mark with x</i>):	0 <1	1	2	3	4	> 4

Preventive care (*indicate most recent date and results if known*):

Colonoscopy	yes	no	date:	normal	abnormal
Bone density	yes	no	date:	normal	abnormal
Pap smear	yes	no	date:	normal	abnormal
Mammogram	yes	no	date:	normal	abnormal
Cholesterol profile (<i>Blood sample for cholesterol</i>)	yes	no	date:	normal	abnormal
Mole check (<i>Dermatology evaluation for melanoma</i>)	yes	no	date:	normal	abnormal
