



Patient's Name: _____

Date of Birth: _____

Allergies

Are you allergic to penicillin or any other drugs? Yes No

Please list:

Past Medical History

Date of last exam: _____

Have you ever been hospitalized? Yes No

If yes, what for? _____

Have you ever been tested for hepatitis A, B or C? Yes No

Which hepatitis virus? _____

Have you been vaccinated for hepatitis B? Yes No If yes, date vaccine series completed

Have you been vaccinated for hepatitis A? Yes No If yes, date vaccine series completed

Last Tuberculosis (TB) Screening? _____ Result of TB screening:

Positive Negative

If positive TB screen, date of last chest x-ray: _____ Result of chest x-ray:

Positive Negative

Have you had a sexually transmitted disease? Yes No

Diagnosis: _____

Please describe any current or past medical treatment:

Please list your past surgeries including Cosmetic surgeries:

Social and Preventive History

Circle one: Married Single Divorced Widower Partner

Advanced Directives: If your heart stopped and you stop breathing would you want us to perform CPR? Circle one: Yes No

Primary Language and any other language spoken: _____

Do you currently smoke or chew tobacco? Yes No If no, have you in the past? Yes No

How many packs per day AND how often? _____

Do you drink alcohol, beer, or wine? Yes No If no, have you in the past? Yes No
How many drinks per week? _____

Do you currently drink coffee and/or tea? Yes No

If yes, how many cups per day? _____

Do you exercise daily/weekly? Yes No

Do you use seatbelts while driving? Yes No

Do you wear a helmet while riding a bike? Yes No

Family History

Living Age (or age at death) List serious illnesses

Mother Yes No Age: _____

Illness or Cause of Death: _____

Father Yes No Age: _____

Illness or Cause of Death: _____

Females: Gynecological History

How many times have you been pregnant? _____ Date of last Pap Smear: _____

Have you had an abnormal Pap Smear? Yes No Diagnosis: _____ Follow up: _____

Have you had a sexually transmitted disease? Yes No Diagnosis: _____

Date of last mammogram: _____

Mammogram results: _____

Have you ever had a breast biopsy? Yes No

Biopsy results: _____

By signing below, I hereby certify that to the best of my knowledge all the information I have furnished on this form is complete, true and accurate.

Patient/Legal Guardian Signature _____

Date _____