First Middle Last

GENERAL State of Health
Excellent Good Fair Poor

Marital Status:
Single Married Widowed
Seperated Divorced
Occupation or Job:

Number of Children:

Number of People in Household:

Do you Smoke?
Packs per day
Number of Smoking Years

Do you Drink Alcoholic Beverages?
Hou much?

Are you on any type of diet?
Type

Religion: Protestant Denomination
Catholic
Other

YOUR IMMUNIZATIONS:
Date of Last Booster
Adults 1. Polio ______
2. Tetanus ______
3. Diptheria ______

When did you have your last physical exam:
Year ______ Result ______ Vision Test ______
TB Skin Test ______ Chest X-ray ______
Pap Smear ______ Glaucoma (Eye) ______
Were any of the tests positive? ______

Environmental Risks or Exposures
Radiation Noise (Excessive)
Asbestos Chemicals
Others?

Childhood Illnesses
Mumps Chicken Pox Rheumatic Fever
Measles Scarlet Fever Meningitis
Rubella Polio

ALLERGIES:
Medicines: Others:

Previous Hospitalizations and/or Surgery

	Illness	Date
1.		
2.		
3.		
4.		

CURRENT MEDICATIONS (include over the counter)
1. 5.
2. 6.
3. 7.
4. 8.

Form of Birth Control:

Chart # ______

Doctor ______

Date history was received: ______

Date of Birth:

FAMILY HISTORY

	Age	Present Illness	Cause of Death
Mother			
Father			
Brothers and Sisters 1.			
2.			
3.			

Is There A Family History Of: (Check Appropriate Box)

High Blood Pressure		Depression	
Sugar Diabetes		Psychiatric Illness	
Overweight		Alcoholism	
High Cholesterol		Bleeding Disorder	
Heart Attack		Anemia	
Stroke		Glaucoma	
Tuberculosis		Cancer	
Lung Problem		A. Lung	
Asthma		B. Breast	
		C. Colon	
		D. Stomach	
		E. Other	

PAST MEDICAL HISTORY

Have you Had Any Of The Following Illnesses Or Disorders?
(Check Appropriate Box)

Heart Problems		Birth Defects	
High Blood Pressure		Arthritis	
Sugar Diabetes		Thyroid Problem	
Overweight		Gout	
Stroke		Anemia	
Chronic Bronchitis		High Cholesterol	
Emphysema (Lung)		Bleeding Problem	
Asthma		Glaucoma (Eyes)	
Tuberculosis		Suicide Attempt	
Hepatitis (Jaundice)		Depression	
Ulcer		Venereal Disease (VD)	
Urinary Stones		Other Disorders of:	
Urinary infections		Breast	
Seizures (Fits)		Blood Vessels	
Migraine		Stomach	
Decreased Vision		Bowel	
Decreased Hearing		Gallbladder	
Black Lung Problem		Pancreas	
Amputations		Kidneys	

FEMALE HISTORY:
Age of onset of periods ______
Are your periods regular? ______
Number of pregnancies: ______
Number of miscarriages: ______
Age of "Change of Life": ______
Do you do self breast exam? ______