Past Medical History:
Do you have or ever had any of the following conditions? Please check all that apply:

☐ Acne
☐ Acute Myocardial Infarction (Heart Attack)
☐ Anemia (Low Blood Count)
☐ Anxiety
☐ Arthritis
☐ Asthma
☐ Autoimmune Disorder (Lupus/Scleroderma)
☐ Benign Polyps of The Large Intestine (Colon Polyps)
☐ Benign Prostatic Hypertrophy (Enlarged Prostate)
☐ Blood Transfusion Complications
☐ Breast Cancer
☐ Cancer
☐ Chemotherapy Administration
☐ Chest Pain (Angina)
☐ Chronic Liver Disease
☐ Chronic Obstructive Pulmonary Disease
☐ Colon Cancer
☐ Depression
☐ Diabetes Mellitus
☐ Diverticulosis
☐ Dizziness
☐ Easy Bruising Tendency
☐ Edema
☐ Emotional Disturbance
☐ Factor VII Deficiency (Hemophilia)
☐ Fainting (Syncope)
☐ Fibromyalgia
☐ Gallbladder Disease
☐ Gastric Ulcer
☐ Headache
☐ Heart Disease
☐ Heartburn
☐ Hepatic Disease (Liver Disease)
☐ Hepatitis
☐ HIV Infection
☐ Hypercholesterolemia
☐ Hypertension
☐ Infection of Kidney
☐ Irritable Bowel Syndrome
☐ Loss of Hearing
☐ Lower Back Pain
☐ Mitral Valve Disorder
☐ Murmurs
☐ Nephrolithiasis (Kidney Stones)
☐ Obesity
☐ Obstructive Sleep Apnea
☐ Osteoarthritis
☐ Osteoporosis
☐ Pain During Urination
☐ Pain When Defecating (Bowel Movement)
☐ Peripheral Vascular Disease (Poor Circulation Hands and Feet)
☐ Pneumonia
☐ Prostate Cancer
☐ Prostate Enlargement
☐ Pulmonary Disease (Lung Disease)
☐ Recent Methicillin-resistant Staff (MRSA)
☐ Red Blood in Bowel Movement
☐ Rheumatic Fever
☐ Rubella
☐ Seizure Disorder
☐ Sinusitis
☐ Stroke Syndrome
☐ Taking Aspirin
☐ Thromboembolic Disease (Blood Clot Disorder)
☐ Thyphlilosis
☐ Thyroid Disorder
☐ Transient Ischemic Attack (Mini Stroke)
☐ Transient Limb Paralysis
☐ Tuberculosis
☐ Vaginitis
☐ Varicose Veins
☐ Vision Problems
☐ Other:

☐ No Past Medical History
### Hospitalization:

<table>
<thead>
<tr>
<th>Hospitalization</th>
<th>Date</th>
<th>Reason for Hospitalization</th>
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<tbody>
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### Surgery:

<table>
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<tr>
<th>Surgery</th>
<th>Date</th>
<th>Reason for Surgery</th>
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</table>

☐ No Surgical or Hospitalization History

### Family History:

Please check all that apply:

<table>
<thead>
<tr>
<th>Indicate Family Member</th>
<th>Indicate Family Member</th>
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</thead>
<tbody>
<tr>
<td>☐ Alzheimer's Disease</td>
<td>☐ FH-Unattainable-Patient Adopted</td>
</tr>
<tr>
<td>☐ Anemia</td>
<td>☐ Heart Disease</td>
</tr>
<tr>
<td>☐ Benign Polyps of The</td>
<td>☐ Hepatic Disorder</td>
</tr>
<tr>
<td>Large Intestine (Colon Polyps)</td>
<td>☐ Hypercholesterolemia</td>
</tr>
<tr>
<td>☐ Bladder Cancer</td>
<td>☐ Hypertension</td>
</tr>
<tr>
<td>☐ Breast Cancer</td>
<td>☐ Osteoporosis</td>
</tr>
<tr>
<td>☐ Cancer</td>
<td>☐ Ovarian Cancer</td>
</tr>
<tr>
<td>☐ Cervical Cancer</td>
<td>☐ Prostate Cancer</td>
</tr>
<tr>
<td>☐ Chronic Bronchitis</td>
<td>☐ Pulmonary Disease</td>
</tr>
<tr>
<td>☐ Chronic Obstructive</td>
<td>☐ Renal Disease</td>
</tr>
<tr>
<td>Pulmonary Disease</td>
<td>☐ Sickle Cell Anemia</td>
</tr>
<tr>
<td>☐ Colon Cancer</td>
<td>☐ Stroke Syndrome</td>
</tr>
<tr>
<td>☐ Diabetes Mellitus</td>
<td>☐ Tay-Sachs Disease</td>
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<tr>
<td>☐ Emphysema</td>
<td>☐ Thromboembolic Disease (Blood Clot Disorder)</td>
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</tbody>
</table>

☐ No Family Medical History

Form 73087 (Rev. 05/08) JG 08.2865
**Social History:**

**Marital Status:**

- □ Married
- □ Single
- □ Widowed
- □ Separated
- □ Divorced
- □ Life Partner

Children’s Ages: __________________________________________________________

Please check all that apply:

- □ Alcohol Use
  - Alcohol Use/Week ______________
  
- □ Drug Use (Recreational)
  - Explain: ___________________________________________________________________________________
  
- □ Using Intravenous Drugs
  - Explain: ___________________________________________________________________________________
  
- □ Previous History of Smoking
  - Date Quit ______________
  - Packs Per Day ______________
  - Number of Attempts to Quit ______________
  - Years of Smoking ______________

- □ No History of Smoking

- □ Smoking a Pipe
  - Times per day ______________
  - How many years? ______________

- □ Smoking Cigarettes
  - Packs Per Day ______________
  - How many years? ______________

- □ Wishing to Stop Smoking
  - Chew Tobacco (Chewing Nicotine-Containing Substances)
    - Times per day ______________
    - How many years? ______________

- □ Cigars
  - Number per day ______________
  - How many years? ______________

- □ Exercise Habits
  - Times per week ______________

- □ Exercising Regularly

- □ Being Sedentary (Do not exercise)

- □ Sexually Active

- □ Occupation
  - List All: ________________________________________________________________________________
  
- □ Travel (Recently Out of the Country)
  - Where? ________________________________________________________________________________

Do you have an advanced directive? □ Yes □ No
Allergies:

<table>
<thead>
<tr>
<th>Allergy</th>
<th>Reaction</th>
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Medications:

Include vitamins, herbal supplements and over the counter medications

<table>
<thead>
<tr>
<th>Medications</th>
<th>Dosage</th>
<th>Frequency</th>
<th>Reason for Taking</th>
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Have you participated in any clinical trials or used experimental drugs?  □ Yes □ No

Explain:

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

Are you pregnant? □ Yes □ No  LMP Date: ______________________

Is there anything else about your medical history that we should know?

____________________________________________________________________________________________________________________

____________________________________________________________________________________________________________________

Review of Systems:

Do you have the following symptoms? Please indicate Yes or No:

Fever □ Yes □ No  Abdominal Pain □ Yes □ No
Recent Wt Loss □ Yes □ No  Pain on Urination □ Yes □ No
Feeling Tired □ Yes □ No  Joint Pain □ Yes □ No
Eyesight Problems □ Yes □ No  Limb Pain □ Yes □ No
Loss of Hearing □ Yes □ No  Skin Lesions □ Yes □ No
Nasal Discharge □ Yes □ No  Dizziness □ Yes □ No
Sore Throat □ Yes □ No  Limb Weakness □ Yes □ No
Hoarseness □ Yes □ No  Difficulty Walking □ Yes □ No
Chest Pain □ Yes □ No  Muscle Weakness □ Yes □ No
Shortness of Breath □ Yes □ No  Easy Bruising □ Yes □ No
Cough □ Yes □ No  Seasonal Allergies □ Yes □ No

Patient Signature __________________________ Date ______________

I certify that I have reviewed the above information with the patient.

Physician Signature __________________________ Date ______________