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HISTORY FORM

Date: _____
Name: _____ Sex: F/M D.O.B. _____ SSN: _____
Address: _____
Phone: () _____ Occupation: _____ Drug Store: _____
Contact Person: _____ Phone: () _____
[Optional] Race: [] White [] Black [] Native American [] Hispanic [] Asian, Other: _____
[Optional] First Language: [] English [] Spanish, Other: _____

I. Past Medical History

Have you ever had or do you have: Check [] all that apply.

<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Mumps	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Liver Disease
<input type="checkbox"/>	Whooping Cough	<input type="checkbox"/>	Childhood Disease	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	Diphtheria	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Lung Disease
<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	Mental Illness
<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Venereal Disease	<input type="checkbox"/>	Heart Disease
<input type="checkbox"/>		<input type="checkbox"/>	Kidney Disease or Infection	<input type="checkbox"/>	Alcoholism

II. Past Family History

Have any of your brothers, sisters, father, mother, or grandparents ever had: Check [] all that apply.

<input type="checkbox"/>	Heart Disease	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Cancer
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Allergy - Asthma
<input type="checkbox"/>	Tuberculosis (TB)	<input type="checkbox"/>	Mental Problems
<input type="checkbox"/>		<input type="checkbox"/>	Other:

III. Social History

- A. Do you drink alcohol? _____ Do you exercise regularly? _____
B. Do you smoke? _____ Quantity: _____ (packs/day) Number of years: _____
C. Do you use other tobacco products? _____
D. Do you use other drugs? _____ What kind? _____

IV. Past Hospitalizations/Surgeries, Reasons and Dates:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

V. Have you ever had a serious accident, if yes, please describe _____

VI. List all Medications that you currently take (List additional medications on back of form and check here []):

Name	Dosage	Name	Dosage

VII. Allergies to Medicines (list): _____
Allergies to anything else (list): _____

VIII. Immunizations Current? [] Yes [] No [] I don't know

IX. Women Only: gynecological History

Menstrual: Age onset _____ Regular _____ Duration _____ Problems _____
Number of pregnancies: _____ Number of Live Births _____ Miscarriages _____
Date of Last Pap Smear? _____