

PERSONAL MEDICAL HISTORY (indicate if you have or have had any of the following conditions)					
HEENT	Cataracts Other HEENT history	Glaucoma	Recurrent ear infections	Recurrent sinusitis	
Endocrine	Diabetes mellitus Other endocrine history	Graves disease	Hypothyroidism	Hyperthyroidism	
Respiratory	Allergies/hay fever Other respiratory history	Asthma	COPD	Sleep apnea	
Cardiovascular	Angina Deep vein thrombosis Hypertension Other CV history	Atrial fibrillation Heart failure Myocardial infarction	Cardiac arrhythmias Heart valve disease Peripheral vascular dx	Coronary artery disease Hyperlipidemia	
Gastrointestinal	Colitis GERD Peptic ulcer disease	Irritable Bowel Syndrome Other GI history	Liver disease	Pancreatitis	
Genitourinary	Chlamydia Kidney disease Urinary Incontinence	Gonorrhea Kidney failure Other GU history	Herpes genitalis Kidney stones	Human papilloma virus Past UTI Syphilis	
Genitourinary - male	Erectile dysfunction	Prostate problems	Testicular problems	Undescended testicle	
Gynecologic	Abnormal pap smear Polycystic ovarian synd	Chronic pelvic pain Recurrent vaginal infect	Endometriosis Other gyn history	PID	
Reproductive history	Age at first period _____ Age at menopause _____ Pregnancy history # of pregnancies _____ # of births _____ # of live births _____ # of abortions (includes miscarriages and elective terminations) _____				
Musculoskeletal	Arthritis	Fractures Gout	Osteoporosis	Other musculoskeletal hx	
Cancer	Blood cancer Endocrine cancer Leukemia Musculoskeletal cancer Stomach cancer	Brain cancer Eye cancer Liver cancer Neurologic cancer Thyroid cancer	Breast cancer GI cancer GU cancer Lung cancer Oral cancer Other cancer history	Colorectal cancer Kidney cancer Lymphoma Skin cancer	
Cancer - female	Cervical cancer	Ovarian cancer	Uterine cancer		
Cancer - male	Prostate cancer	Testicular cancer			
Infectious disease	AIDS Chicken pox Polio Positive PPD Vanc resistant enterococc	Hepatitis Rheumatic fever Other inf disease history	HIV Measles Rubella	MRSA Mumps Tuberculosis	

Integumentary	Acne	Eczema	Psoriasis	Other integumentary hx		
Neurologic	ADHD Autism Multiple sclerosis Seizures	Dementia Peripheral neuropathy Stroke	Developmental delay Restless leg syndrome Transient ischemic attack	Headaches Other neurological hx		
Psychiatric	Anxiety Other psychiatric history	Bipolar disorder	Depression	Schizophrenia		
Genetic/metabolic	Cystic fibrosis Other metabolic history	Down syndrome	Other genetic history			
Events	Anaphylaxis	Gunshot wound	MVA	Other events		
Disabilities	Hearing deficit Other disabilities	Vision deficit	Hemiparesis	Paraplegia	Quadriplegia	
SURGICAL HISTORY (indicate if you have had any of the following surgical procedures)						
Head/Ears/Eyes/Nose/Throat	Cataract extraction Other head surgery Other nasal surgery	Laryngectomy Other eye surgery Other throat surgery	Tonsillectomy Other ear surgery			
Endocrine	Parathyroidectomy	Thyroid surgery	Other endocrine surgery			
Respiratory	Bronchoscopy	Lobectomy	Other chest surgery			
Cardiovascular	Angiogram Coronary artery bypass gr Valve replacement	Angioplasty Coronary stent Other cardiac surgery	Carotid endarterectomy Heart transplant	Pacemaker		
Gastrointestinal	Appendectomy Splenectomy	Cholecystectomy Other GI surgery	Colectomy	Gastric bypass		
Genitourinary	Bladder surgery Other GU surgery	Kidney stone extraction	Nephrectomy			
Genitourinary - male	Prostatectomy	TURP	Vasectomy			
Gynecologic	C-Section Tubal ligation	Cervical conization/LEEP Other gyn surgery	Hysterectomy	Oophorectomy		
Musculoskeletal	Joint replacement	Other musculoskeletal srg				
Integumentary/Skin	Skin cancer removal	Other integumentary surg				
Neurologic	Craniotomy	Spinal surgery	Other neurologic surgery			
Breast	Breast biopsy	Lumpectomy	Mastectomy	Other breast surgery		
FAMILY MEDICAL HISTORY (indicate if any of your blood relatives have had the following conditions)						
	Diabetes mellitus Coronary artery disease Other cardiac disorders Colorectal cancer Hepatitis B Depression Blood disorders Other	Thyroid disease Hyperlipidemia Kidney disease Ovarian cancer Tuberculosis Drug abuse Rheumatoid disease	Asthma Hypertension Breast cancer Prostate cancer Dementia Mental illness Hearing problems	Atherosclerosis Other cancer Stroke Autoimmune disease Vision problems	Alcoholism	

SOCIAL HISTORY (please answer the following questions regarding your health and habits)

<i>Marital status</i>					
<i>Tobacco status</i>	Has never used tobacco Not considering quitting Other	Considering quitting Quit date established	Former tobacco use Secondhand exposure		
<i>Packs/day</i>					
<i>Pack years = # of packs/day multiplied by years smoked</i>	< 10 pack years 10-25 pack years	25-50 pack years	> 50 pack years		
<i>Alcohol intake</i>	None 0-2 drinks per day	2+ drinks per day	Other		
<i>Substance use</i>	Denies use Tranquilizers/sedatives Inhalants	Marijuana Opiates Other	Cocaine/crack Painkillers	Amphetamines Club/designer drugs	Hallucinogens

Additional history _____

