

PATIENT HISTORY

Name: _____ Date of Birth _____ Age _____
Occupation: _____ Primary Language _____ Marital Status _____
Formal Education: High School _____ College _____ Other _____

Past Medical History:

- | | | | | |
|-------------------------------------|----------------------------------------------|------------------------------------------------------|------------------------------------------|-----------------------------------------|
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Gallbladder Disease | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Pertussis | <input type="checkbox"/> Gastrointestinal Disorders | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Tetanus | <input type="checkbox"/> Eating Disorders | <input type="checkbox"/> Asthma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Prostate Disease | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Ulcers |
| <input type="checkbox"/> Chickenpox | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Depression | <input type="checkbox"/> Kidney stones | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Gout |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Peripheral Vascular Disease | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Mental illness |

Hospitalizations and surgeries (List reason and date):

Medications (List all with dosages and frequency including vitamins, herbs, and contraceptives):

Allergies / Side Effects:

Women only:

Last Period _____ Age at 1st Period _____ # of Pregnancies _____ Outcomes _____
Age of 1st sexual activity _____ # of sex partners _____ Hormone or Birth Control Pill use _____

Men only: Age at 1st sexual activity _____ # of sex partners _____

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