1. How would you **describe your health**?

___Excellent ___Very Good ___Good ___Fair ___Poor

2. Are you taking any **prescription medicines**?

___Yes. Please list your medicines below OR ___I brought my pill bottles or a list.

___No, I do not take any prescription medicines. (If no, go to question #5.)

Name of medicine	**Amount/ size of pill**	**How many pills or doses do you take at**
Example: Furosemide	20 mg	2 morning 2 noon __dinner ___ bed
		___morning ___noon ___ dinner ___bed
		___morning ___noon ___ dinner ___bed
		___morning ___noon ___ dinner ___bed
		___morning ___noon ___ dinner ___bed
		___morning ___noon ___ dinner ___bed

		___morning ___noon ___ dinner ___bed

(Please use the back of this form if you have more prescription medicines.)

3. What **over-the-counter medicines**, do you take regularly?

___Pain reliever (for example: Tylenol, Advil, Motrin, Aleve, aspirin)

___Vitamins

___Antacid (for example: Tums, Prilosec)

___Herbal medicine (please list)

_____

___Other (please list)

_____

_____

___None—I do not take any over-the-counter medicines regularly.

4. Have you ever had any **allergic reaction (bad effects) to a medicine** or a shot?

___Yes. (Please write the name of the medicine and the effect you had.)

___No, I am not allergic to any medicines.

Medicine I am allergic to	**What happens when I take that medicine**
Example: Atenolol	I get a rash

5. Do you get an **allergic reaction (bad effect)** from any of the following? (Check all that apply)

___latex (rubber gloves)

___eggs

___shellfish

___Other (please describe)

_____

_

___No—I have no allergies that I know of.

For Women Only

6. Have you ever been **pregnant**? _Yes ___No

How many times?_____

_____

How many children have you given birth to?_____

7. Have you had a **PAP smear**? _Yes ___No

Date of last one

_____

___

8. Have you ever had a **PAP smear that was not normal**? ____Yes ___No

9. Have you had a **mammogram** (breast x-ray)? ____Yes ___No

Date of last one_____

Family History

What medical problems do people in your family have?

Family Member	Medical Problems
Mother:	___Diabetes (sugar) __High blood pressure __Heart problems ___Cancer ___Other: _____
Father:	___Diabetes (sugar) __High blood pressure __Heart problems ___Cancer ___Other: _____
Sisters:	___Diabetes (sugar) __High blood pressure __Heart problems ___Cancer ___Other: _____
Brothers:	___Diabetes (sugar) __High blood pressure __Heart problems ___Cancer ___Other: _____

History of Medical Conditions

Have you **ever** had any of the following conditions? (Check all that apply)

___Anemia (low iron blood) ___Asthma (wheezing) __Diabetes (sugar)

___Heart Trouble ___Hemorrhoids (piles) ___Cancer

___Hepatitis (yellow jaundice) ___Tuberculosis (TB) ___Liver Trouble

___Pneumonia ___Rheumatic fever ___Ulcers

___Stroke ___High Blood Pressure

___Skin problems ___Depression (feeling down or blue)

___Epilepsy (fits, seizures) ____Anxiety (nerves, panic attacks)

___VD, STD (syphilis, gonorrhea, chlamydia, HIV)

___Other_____