PATIENT NAME: LAST FIRST MIDDLE INITIAL	DOB:
Preferred Name:	Preferred Pronoun/Gender:

CURRENT MEDICATIONS Please list name of medication / dose / frequency of use	**CURRENT DOCTORS** Please list doctor's name / specialty

MEDICATION ALLERGIES Please list medication name / reaction	**OTHER ALLERGIES** (e.g. nuts, pollen, etc.) Please list allergen / reaction

Do you have an **Advanced Health Care Directive** or living will? ☐ Yes, I have completed one. ☐ No, but I am currently working on it. ☐ No, not at all.	Do you have a **Durable Power of Attorney**? ☐Yes ☐No If yes, who is it? _____
Smoking Status ☐ Never Smoker ☐ Current Some Day Smoker ☐ Current Everyday Smoker ☐ Former Smoker ☐ Cigarettes ☐ Cigars ☐ Pipes ☐ Vaping/E-cigarettes Start Date:_____ Quit Date:_____ Packs Per Day:_____ Have you ever used **smokeless tobacco** (e.g. chewing tobacco)? ☐Yes ☐No Start Date:_____ Quit Date: _____	**Alcohol Use** ☐Yes ☐Not Currently ☐Never Types: ☐Wine ☐Beer ☐Shots of liquor ☐Other: How **often** do you have a drink containing alcohol? ☐Never ☐Monthly or less ☐2-4 times a month ☐2-3 times per week ☐4 or more times per week How **many** drinks containing alcohol do you have when you are drinking? ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐10 or more
Date of last **influenza vaccination** (flu shot):	When was your last **dental exam**? _____ Who is your **dentist**? _____
COVID Vaccination ☐Pfizer ☐Moderna ☐Johnson & Johnson Dates: 1st dose: _____ 2nd dose: _____	When was your last **eye exam**? _____ Who is your **eye doctor**? _____

Booster (if applicable): _____	

Marital Status: ☐ Single ☐ Not married but in a relationship ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Number of Children:	**Occupation**: If **retired**, what year did you retire?	**Belief or Religion**:

What do you do for **exercise**? How often & for how long?	Do you follow any special **diet**? If so what kind?

Sexually Active: ☐ Yes ☐ No

Partners: ☐Female ☐Male ☐Both Male & Female

History of sexually transmitted infections? _____
(If so please list what type and if treatment received)

MEDICAL HISTORY

Stroke TIA (Transient Ischemic Attack) Seizure Migraines Memory disorder Multiple sclerosis Parkinson's disease

High blood pressure High cholesterol
Heart attack Heart disease Heart failure Heart murmur Abnormal heart rhythms Pacemaker Implantable defibrillator

Asthma COPD Cystic fibrosis Bronchiectasis Pneumonia Tuberculosis Pulmonary fibrosis
Interstitial lung disease Sleep apnea

Heartburn Ulcers Liver problem: _____ Hepatitis Gallstones Pancreatitis Irritable bowel syndrome
Inflammatory bowel disease Hemorrhoids

Kidney problems Kidney stones Frequent UTIs Enlarged prostate Erectile dysfunction Urinary incontinence

Anemia Abnormal blood counts Blood clots Heavy menses

Diabetes Thyroid disease Osteopenia/Osteoporosis

Arthritis Gout Falls

Autoimmune conditions (please specify):

Cancer (please specify):

Glaucoma Cataracts Macular degeneration Hearing loss Tinnitus Vertigo

HIV/AIDS Abnormal pap smears (Date:)

Skin conditions (please specify):

Positive TB test Have you been treated? No Yes, treated with: Last chest x-ray date: _____

Blood transfusions

Depression Anxiety Mental health conditions (please specify):

☐Other:

SURGICAL HISTORY	OTHER HOSPITALIZATIONS
Please list type of surgery / date / name of surgeon:	Please list reason for hospitalization / date / hospital:

FAMILY HISTORY Please list medical conditions such as high blood pressure, heart attack, stroke, diabetes, mental health conditions, cancer (and type), etc.	
MOTHER:	FATHER:
SISTER:	BROTHER:
DAUGHTER:	SON:
Other family members (maternal/paternal grandmother or grandfather, etc.):	

Any **recreational drug use** (e.g. marijuana)? ☐ Never ☐ Current Some Day ☐ Current Every Day ☐ Former Use

Types:_____ Quit Date:_____

HEALTH MAINTENANCE (When did you last have the following tests?)		
	Date	Physician who performed or ordered the exam?
Pap Smear		
Mammogram		
Colonoscopy or Stool Occult Blood Test		
DEXA (Bone Density Scan)		