Name _____ **Today's Date** _____
Birthdate _____

MEDICATIONS:List of medications (Name) currently taken (including over-the-counter medications) *and any additional medications on the back of the form*

Medication Name	Dose/Frequency

ALLERGIES: Allergies you have and your reaction

Food or Drug Allergy	Reaction

IMMUNIZATIONS: Indicate if and when you had these immunizations

Immunization		Date Received
Flu shot	Y N	
Pneumonia shot	Y N	
Shingles shot	Y N	
Tetanus shot	Y N	
Did the tetanus shot include whooping cough (pertussis)?	Y N	

MEDICAL PROBLEMS: Any significant illnesses that you have/had

Problem	Year

SURGERIES:

Surgery	Date

SCREENING: **When was your last?**

Screening	Year	Screening	Year
Physical Exam		Pap Smear	
Colonoscopy		Mammogram	
Prostate Exam		Bone Density Test	

FAMILY HISTORY:

Relation	Age (or age at death)	Medical Problems or Cause of Death
Father		
Mother		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		
Brother/Sister		
Brother/Sister		
Brother/Sister		

Brother/Sister		
Other (uncles/aunts,etc)		

HAS ANY FAMILY MEMBER HAD?

Cancer of the breast	Y N	Heart Disease	Y N
Cancer of the colon	Y N	High Blood Pressure	Y N
Cancer of the prostate	Y N	Depression	Y N
Another type of cancer	Y N	Other mental illnesses	Y N
Diabetes	Y N	Alcoholism	Y N

SOCIAL MEDICAL HISTORY:

Marital Status: Single Married Divorced Separated Widowed
Partnered Civil Union In a Relationship Other

Sexual Orientation: Heterosexual Homosexual Bisexual Other

Occupation: _____
Hobbies: _____
DO YOU:

Drink alcohol? Y N *Formerly?* Y N *Year Quit?* _____	**Type of alcohol?** **Amount per day/week/month?** _____
Use tobacco? Y N *Formerly?* Y N *Year Quit?* _____	**Smoke** Y N **Amount per day?** _____ **Chew** Y N **Amount per day?** _____
Use recreational drugs? Y N *Formerly?* Y N	**What type?**
Exercise regularly? Y N	**What type?** **Times per week?**
Are you concerned about your risk of HIV/AIDS? Y N	