Date: **Name/ID#:** **M F** **DOB:**

FAMILY HISTORY: **(Indicate if any of your blood relatives have or have had any of the following)**

Illness	Relation	Illness	Relation
AIDS/HIV		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Blood disorder		Lung disease	
Bowel disease		Psychiatric care	
Cancer		Stroke	
Chemical dependency		Thyroid problems	
Depression		Tuberculosis	
Diabetes		Other (please list)	
Epilepsy/convulsions			
Glaucoma, eye disease			

SOCIAL HABITS: **(Have you ever used any of the following?)**

Cirlce One		For how long?	When stopped
Alcohol Yes No	Drinks per week?		
Caffiene Yes No	Ounces per day?		
Tobacco Yes No	Packs per day?		
Street Drugs Yes No	Frequency?		

Are you sexually actice? Yes No

Do you exercise safe sex precautions? Yes No

Would you like information on safe sex precautions today? Yes No

PREVENTIVE CARE: **(Please indicate the last time you had the following. mm/dd/yy)**

Exam/Vaccine	Date	Exam/Vaccine	Date
Cholesterol screening		Flu Shot	
Lipid Profile		Pneumonia vaccine	
Eye Exam pupils Dilated? Yes No		Sigmoidoscopy	
Results:		Stool occult blood test	
Hearing test		Tuberculosis (TB) skin test	
Hepatitis vaccine		Tetanus/Diptheria booster	

Describe any abnormal results: _____

Female patients only:	Date (mm/dd/yy)	Results	Performed by:
Pap Smear			
Clinical breast exam			
Mammogram			

Menstrual: age of onset:_____ ____Regular ____Irregular _____ Pain/cramps with menstrual flow?

Date of last menstrual period: _____

Current birth control method: _____ Number of pregnancies: _____ Number of live births: _____

Complications: _____

Do you perform self-breast exams each month? _____ Yes _____No

Male patients only:	Date (mm/dd/yy)	Results	Performed by:
Prostate exam			
PSA (prostate specific antigen)			

Do you perform self-testicle exams each month? _____ Yes _____No