NAME _____

FAMILY HISTORY	ALIVE & WELL	DECEASED	FOLLOW THE LINES ACROSS THE PAGE AND MARK THE APPROPRIATE BOX CAUSE OF DEATH (AGE)	HIGH BLOOD PRESSURE	HEART DISEASE	EPILEPSY	DIABETES	CANCER	ASTHMA	HAYFEVER	ARTHRITIS	KIDNEY DISEASE	GLAUCOMA	STROKE	MIGRAINE	MENTAL ILLNESS	ALCOHOLISM	BLEEDS EASILY	ANEMIA	PSORIASIS	ECZEMA
FATHER																					
MOTHER																					
BROS / SIS																					
BROS / SIS																					
BROS / SIS																					
BROS / SIS																					
MOTHER'S RELATIVES																					
FATHER'S RELATIVES																					

HOSPITAL ADMISSIONS Indicate the year you were admitted to hospital and the reason. Do not include normal pregnancies.

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

MEDICATIONS LIST ALL MEDICATIONS THAT YOU ARE NOW TAKING. INCLUDE OVER THE COUNTER Rx.

NAME	STRENGTH	HOW OFTEN	NAME	STRENGTH	HOW OFTEN

DRUG ALLERGIES _____

MEDICAL HISTORY Mark (C) for current problems. Check (✓) box and indicate age when you had any of the following symptoms or diseases.

MAIN PROBLEMS (1) _____ (2) _____ (3) _____

- ☐ Decreased hearing
- ☐ Ringing in ear
- ☐ Ear infections - frequent
- ☐ Dizzy spells ☐ Glaucoma
- ☐ Failing vision ☐ Cataracts
- ☐ Double or blurred vision
- ☐ Eye infections - frequent
- ☐ Nose bleeds ☐ Sinusitis
- ☐ Sore throats - frequent
- ☐ Hayfever ☐ Allergies
- ☐ Hoarseness - prolonged
- ☐ Pneumonia / Pleurisy
- ☐ Bronchitis / Chronic cough
- ☐ Asthma / Wheezing

Shortness of breath:

- ☐ On Extertion ☐ Lying Flat
- ☐ Chest Pain
- ☐ High blood pressure
- ☐ Heart murmur ☐ Palpitations
- ☐ Irregular pulse ☐ Fainting spells
- ☐ Swollen ankles
- ☐ Leg pain when walking
- ☐ Varicose veins ☐ Phlebitis
- ☐ Loss of appetite - recent
- ☐ Difficulty swallowing
- ☐ Indigestion or heartburn
- ☐ Persistant nausea / Vomiting
- ☐ Peptic ulcers
- ☐ Abdominal pain - chronic
- ☐ Change in bowel habits
- ☐ Diarrhea ☐ Constipation
- ☐ Diverticulosis ☐ Blood in stools
- ☐ Hemorrhoids ☐ Hernia
- ☐ Gall bladder trouble
- ☐ Jaundice ☐ Hepatitis
- ☐ Urine infections - frequent
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Control of urination
- ☐ Decreased force in urination
- ☐ Kidney stones
- ☐ Venereal Disease
- ☐ Chronic fatigue
- ☐ Weight loss - recent
- ☐ Anemia ☐ Bruise easily
- ☐ Cancer
- ☐ Diabetes ☐ Thyroid disease
- ☐ Convulsions / Seizures
- ☐ Stroke
- ☐ Tremor / Hands shaking
- ☐ Numbness / Tingling sensations
- ☐ Headaches - frequent
- ☐ Arthritis / Rheumatism ☐ Gout
- ☐ Back pain - recurrent
- ☐ Bone fracture / Joint injury
- ☐ Foot pain ☐ Cold numb feet
- ☐ Rashes ☐ Hives
- ☐ Psoriasis ☐ Eczema
- ☐ Sleeping - difficulty
- ☐ Nervousness ☐ Depression
- ☐ Memory loss ☐ Mental illness
- ☐ Moodiness ☐ Phobias
- ☐ Recent hair loss
- ☐ Herpes ☐ Chlamydia ☐
- ☐ Chicken Pox ☐ Polio ☐ Mumps
- ☐ Measles ☐ German Measles
- ☐ Rheumatic ☐ Scarlet Fever ☐ T.B.

IMMUNIZATION	YEAR OF LAST INJECTION	
___ PNEUMONIA	___ FLU	___ TETANUS
___ DIPTHERIA	___ MEASLES	___ MUMPS
___ RUBELLA	___ POLIO	___ HEPATITIS

Females - Menstrual History

Age of onset _____ ☐ Reg ☐ Irreg

_____ Days of Flow _____ Length of Cycle

☐ Pain / Cramps with menstrual flow

No. of pregnancies _____ No. of Live Births _____

No. of Miscarriages _____

Birth Control method _____

☐ Flushing / Menopause

SOCIAL HISTORY

Marital Status _____ Children (ages & any medical problems) _____

Smoking history (packs per day) _____

Education (level) _____ Military _____ Occupation _____

Work hazards or exposures (past & present) _____

Hobbies _____ Travel _____ Pets _____

Exercise (type & frequency) _____

Nutrition _____ Illicit drug use / abuse (or history of) _____

Alcohol (type & frequency) _____

Caffeine (type & cups per day) _____

HIV RISK FACTORS: Please check all applicable - now or in the past.

☐ IV drug use ☐ Anal Intercourse ☐ Hemophilia

Blood transfusion between 1977 & 1985 _____

Multiple sex partners or partners with known high risk history _____