



**MEDICATIONS** What prescription **and** non-prescription medicines are you taking on a regular basis? (Include vitamins, aspirin, laxatives, birth control pills, injectables, alternative medicines, etc.). Please bring prescription bottles with you at time of appointment.

Prescription Name	Dose	Frequency	Non-Prescription	Dose	Frequency

**ALLERGIES/SENSITIVITIES** Are you sensitive to any medication or substance?  yes  no  don't know

Drug Name	Reaction	Substance Name	Reaction

**PERSONAL HABITS**

**Tobacco Use/Exposure:**

Do you smoke cigarettes?  Yes  No  
 How many packs per day? \_\_\_\_\_ Since when? \_\_\_\_\_  
 Do you want to quit?  Yes  No  
 Did you smoke in the past?  Yes  No  
 How many packs per day? \_\_\_\_\_ Date Started \_\_\_\_\_ Date Quit \_\_\_\_\_  
 Are you currently exposed to second hand smoke?  Yes  No where \_\_\_\_\_

**Substance Use:**

Do you drink alcohol?  Yes  No  
 What? \_\_\_\_\_ How often? \_\_\_\_\_ How much? \_\_\_\_\_  
 If yes,  
 • has drinking ever been a problem in any area of your life (family, work, driving, etc.)?  Yes  No  
 • do you feel that your health would be better if you decreased or stopped drinking?  Yes  No  
 Have you ever used drugs such as cocaine or IV drugs?  Yes  No  
 Have you ever been treated for a drinking or a drug problem?  Yes  No

**Other:**

Do you exercise regularly?  Yes  No  
 If so, how? \_\_\_\_\_  
 Have you ever had a colonoscopy?  Yes (Date \_\_\_\_\_)  No

**SAFETY** Do you regularly use:

Seatbelt	<input type="checkbox"/> yes <input type="checkbox"/> no	Do you have guns in your home?	<input type="checkbox"/> yes <input type="checkbox"/> no
Helmet (bicycle or motorcycle)	<input type="checkbox"/> yes <input type="checkbox"/> no	Are you or have you been a victim of abuse?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are there smoke detectors in your home?	<input type="checkbox"/> yes <input type="checkbox"/> no	Would you like help?	<input type="checkbox"/> yes <input type="checkbox"/> no

**GENITO/REPRODUCTIVE**

**Female**

Date of last pap smear \_\_\_\_\_  
 Age periods began? \_\_\_\_\_ How many days do your periods last? \_\_\_\_\_  
 How often do they occur? \_\_\_\_\_ When did your last period start (date) \_\_\_\_\_  
 If your period has stopped, give the year of your last period \_\_\_\_\_  
 Number of pregnancies \_\_\_\_\_ Number of births \_\_\_\_\_ Number of miscarriages \_\_\_\_\_  
 Type of birth control if used \_\_\_\_\_  
 Do you feel you have a problem with any of the following? (Please specify briefly):  
 Menopausal symptoms \_\_\_\_\_  
 Premenstrual symptoms \_\_\_\_\_  
 Sexual function \_\_\_\_\_

**Male**

Do you perform testicular self exam?  yes  no  
 Have you had a vasectomy?  yes  no  
 Do you have a problem with any of the following?  
 Infertility  yes  no                      Impotence/sexual function  yes  no  
 Scrotum or testicles  yes  no                      Nighttime urination  yes  no  
 Decrease in stream  yes  no                      Change in pattern of urination  yes  no

**Family Health History**

	Living Age	Deceased Age and Cause		Living Age	Deceased Age and Cause
Father			Children 1		
Mother			2		
Spouse			3		
Brother/Sister 1			Maternal Grandmother		
2			Maternal Grandfather		
3			Paternal Grandmother		
4			Paternal Grandfather		

**Please write on the appropriate lines which family members have, or have had, the following medical problems. Please exclude yourself and your spouse, and be sure to list illnesses affecting your parents, grandparents, siblings and children.**

Heart attack/bypass \_\_\_\_\_  
 Other heart disease \_\_\_\_\_  
 High blood pressure \_\_\_\_\_  
 Diabetes \_\_\_\_\_  
 Cancer and type \_\_\_\_\_  
 Thyroid problem \_\_\_\_\_  
 Sickle cell \_\_\_\_\_  
 Asthma \_\_\_\_\_  
 Psychiatric problem \_\_\_\_\_  
 Overuse of alcohol \_\_\_\_\_  
 Seizures \_\_\_\_\_  
 Migraines \_\_\_\_\_  
 Stroke \_\_\_\_\_  
 Kidney disease \_\_\_\_\_  
 Ulcer \_\_\_\_\_  
 Other \_\_\_\_\_

**ADVANCE DIRECTIVE**

Are you familiar with advance directives?  yes  no  
 Have you prepared an advance directive (living will, health care proxy)?  yes  no  
 Have you given us a copy of your advance directive to put in your medical record?  yes  no  
 In order for your provider to follow your directive, we encourage you to send us a copy.

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