

<b>MEDICAL PROFILE</b>			Date:
Patient Name	<input type="checkbox"/> M <input type="checkbox"/> F	Age	Medical Record #
Date of Birth	Marital Status	Occupation	

**Personal and Family History** Indicate if you or anyone in your family has (or has ever had) any of the following conditions

Description	Patient	Family	Relation / Age	Description	Patient	Family	Relation / Age
Hearing Problems				High Cholesterol			
Heart Disease				Depression / Anxiety			
High Blood Pressure				Migraine Headaches			
Stroke				Arthritis or Gout			
Cancer:				Kidney Stone			
Breast				Kidney Disease			
Colon				Liver Disease			
Prostate				Hepatitis			
Other (where)				Anemia			
Asthma, Bronchitis				Stomach Problems			
Emphysema				Abnormal Bleeding			
Thyroid Disease				Ulcers			
Diabetes				Polio			
Epilepsy or Seizures				Tuberculosis			

**Social History**  
Indicate Usage

Cigarettes <input type="checkbox"/> No <input type="checkbox"/> Yes	Packs Per Day	For How Many Years	Date Quit
Alcohol Drinks <input type="checkbox"/> No <input type="checkbox"/> Yes	How Many Drinks Per Week	How Many Drinks Per Month	
Caffeinated Drinks <input type="checkbox"/> No <input type="checkbox"/> Yes	Cups of Coffee Per Day	Pop/Tea Per Day	
IV Drug Use <input type="checkbox"/> No <input type="checkbox"/> Yes	Childbirth History	No. Pregnancies	No. Live Births
		No. Miscarriages	No. Abortions

**Hospitalizations / Surgeries**

Hospitalization or Surgery	Date	Hospitalization or Surgery	Date

**List Any Prescription Or Over-The-Counter Medications You Are Currently Using**

Medication	Dosage	Medication	Dosage

Are you Allergic To Any Medications? <input type="checkbox"/> No <input type="checkbox"/> Yes - List		
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**Immunizations**

Type of Immunizations	Date	Other Immunizations	Date
Last Pneumonia			
Last Tetanus			
Last Influenza			
Last TB SkinTest			

If Under 18, Are Immunizations Current? <input type="checkbox"/> No <input type="checkbox"/> Yes
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