

<b>NAME:</b>	<b>DOB:</b> <i>mm/dd/yyyy</i>	<b>DATE:</b>
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**HEALTH ASSESSMENT**

What is most important to you about your medical care? *(e.g. communication, prevention, wellness planning)*

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What specific concerns would you like to address with your new clinician?

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**MEDICATIONS & ALLERGIES**

**Please list all your current medications and allergies (including vitamins & supplements)**

Item	Dose	Frequency	Taken for	Prescribed by
1.				
2.				
3.				
4.				
5.				

Allergies to medication and other items:

1.	Reaction:
2.	Reaction:

Preferred pharmacy: \_\_\_\_\_ Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Address: \_\_\_\_\_

**PERSONAL MEDICAL HISTORY**

**Have you ever had any problems with the following: (If yes, please explain.)**

<input type="checkbox"/> Alcohol or substance abuse:	<input type="checkbox"/> Metabolism <i>(diabetes, thyroid etc.)</i>
<input type="checkbox"/> Blood:	<input type="checkbox"/> Muscle, joint, bones:
<input type="checkbox"/> Cancer:	<input type="checkbox"/> Nerves and brain:
<input type="checkbox"/> Digestion:	<input type="checkbox"/> Skin and hair:
<input type="checkbox"/> Ear, nose, throat, eyes:	<input type="checkbox"/> Sleep:
<input type="checkbox"/> ER Visits:      Type:      Date:	<input type="checkbox"/> Social, mental or emotional health:
<input type="checkbox"/> Heart or blood vessels:	<input type="checkbox"/> Surgeries:      Type:      Date:
<input type="checkbox"/> Hospitalizations:      Type:      Date:	<input type="checkbox"/> Women's health:
<input type="checkbox"/> Kidneys or bladder:	Pregnancies (#):      Births (#):      Living Children (#):
<input type="checkbox"/> Lungs:	Other:
<input type="checkbox"/> Men's health:	

**FAMILY MEDICAL HISTORY**

**Please indicate any family members who have had the following:**

<input type="checkbox"/> Alcohol abuse:	<input type="checkbox"/> Bleeding disorders:	<input type="checkbox"/> Deafness:
<input type="checkbox"/> Arthritis:	<input type="checkbox"/> Breast cancer:	<input type="checkbox"/> Dementia:
<input type="checkbox"/> Asthma:	<input type="checkbox"/> Cancer of an unknown type:	<input type="checkbox"/> Depression:
<input type="checkbox"/> Autism:	<input type="checkbox"/> Colon cancer:	<input type="checkbox"/> Diabetes:

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*Family Medical History Continued*

<input type="checkbox"/> Bipolar disorder:	<input type="checkbox"/> Cystic fibrosis:	<input type="checkbox"/> Glaucoma:
<input type="checkbox"/> Heart attack:	<input type="checkbox"/> Lymphoma/Leukemia:	<input type="checkbox"/> Schizophrenia:
<input type="checkbox"/> Heart disease:	<input type="checkbox"/> Osteoporosis:	<input type="checkbox"/> Sickle cell anemia:
<input type="checkbox"/> High blood pressure:	<input type="checkbox"/> Ovarian cancer:	<input type="checkbox"/> Skin cancer:
<input type="checkbox"/> High blood cholesterol:	<input type="checkbox"/> Obesity:	<input type="checkbox"/> Stroke:
<input type="checkbox"/> HIV:	<input type="checkbox"/> Parkinson's disease:	<input type="checkbox"/> Substance abuse:
<input type="checkbox"/> Inherited anemias ( <i>i.e. thalassemia</i> ):	<input type="checkbox"/> Prostate cancer:	<input type="checkbox"/> Thyroid:
<input type="checkbox"/> Inflammatory bowel disease ( <i>e.g. Crohn's disease</i> ):		<input type="checkbox"/> Other cancer:
<input type="checkbox"/> Any other condition that two or more relatives have?		

**SOCIAL HISTORY & LIFESTYLE**

Relationship status: <input type="radio"/> Married or Partnered <input type="radio"/> Single <input type="radio"/> Separated <input type="radio"/> Divorced <input type="radio"/> Widowed					
What is your highest level of education?			Occupation:		
Do you have any children? <input type="radio"/> Yes <input type="radio"/> No					
Name:		DOB		Lives at home? <input type="radio"/> Yes <input type="radio"/> No	
Name:		DOB		Lives at home? <input type="radio"/> Yes <input type="radio"/> No	
Who also lives at home with you?					
Do you have any pets? <input type="radio"/> Yes <input type="radio"/> No					
Have you ever been neglected or abused, physically, emotionally or sexually?					
If yes, are you currently living in an unsafe situation? <input type="radio"/> Yes <input type="radio"/> No					
Do you have more than one sexual partner? <input type="radio"/> Yes <input type="radio"/> No					
Sexual Partners: <input type="radio"/> Men <input type="radio"/> Women <input type="radio"/> Both <input type="radio"/> None					
Do you practice safer sex? ( <i>i.e. use condoms</i> ) <input type="radio"/> Yes <input type="radio"/> No					
What are you using for birth control?					
On average, how many alcoholic drinks do you consume per week?					
In the past year, how many times have you had more than 4 (females), 5 (males) drinks in one day?					
Do you use or have you ever used tobacco products?					
Does anyone smoke around you?					
Do you use or have you ever used recreational drugs? <input type="radio"/> Yes <input type="radio"/> No					
How much caffeine do you consume daily? ( <i>coffee, soda, chocolate etc.</i> )					
Do you have concerns about your diet? <input type="radio"/> Yes <input type="radio"/> No					
What do you do for exercise?					
Do you have: <input type="radio"/> A living will <input type="radio"/> Power of attorney <input type="radio"/> Durable power of attorney for health care					

**HEALTH MAINTENANCE & PREVENTION**

<b>When was the last time you:</b>			
Visited the dentist:		Had a Tetanus booster:	
Had a blood sugar test:		Had a cholesterol test:	
Had a colon cancer screening:			
Type: <input type="radio"/> Colonoscopy <input type="radio"/> Flexible sigmoidoscopy <input type="radio"/> Occult blood stool test ( <i>card</i> )			
<b>Women's Health</b>			
When was your last:   PAP smear?		Mammogram?   Bone density test?	
<b>Men's Health</b>			
When was your last:   Prostate exam?			