



Last Name: _____
 First Name: _____
 Date: _____ Phone: _____

PERSONAL HISTORY

Date of Birth _____ Birthplace: _____
 Marital Status: Single Married Separated Divorced Widowed
 Health of Spouse: _____
 Occupations: _____
 Religion: _____
 Ethnic Background: American Indian Asian African American
 Filipino Caucasian Pacific Islander Other: _____
 Recreation / Exercise: _____
 Sleep: Avg Hrs: _____

ALLERGIES TO MEDICATIONS NO KNOWN ALLERGIES

Substance / Medication	Reaction

HOSPITALIZATIONS & SURGERIES

Year	Hospital	Reason for Hospitalization

Year	Surgery	Reason for Surgery

(continue on back if you need more room)

Date of Last
 PAP Smear: _____ Mammogram: _____
 Tetanus Shot: _____ Pneumova : _____
 Flu Shot: _____ Gardasil: _____
 Zostovax: _____

List Over-the-Counter Medications:

SPIRITUAL ASSESSMENT (optional)

Do you believe in God or a higher power? YES NO
 Would you like to speak with our Chaplain about spiritual matters or grief counseling? YES NO
 Would you like us to pray for: You Your Family Your Health
 Other: _____

YES – during office visit YES – while I'm not present. NO - Not at this time.

ADVANCE DIRECTIVE

- I have executed an Advanced Healthcare Directive, Living Will, or Durable Power of Attorney: _____
- Copy Placed in Chart: _____
- I would like to fill out an Advanced Directive.
- I do not wish to fill out an Advanced Directive at this time.

MY DESIRES CONCERNING LIFE SUPPORT ARE AS FOLLOWS:

- I would never want resuscitation or life support: _____
- I would want resuscitation or life support only if something happened that was easily correctable: _____
- I want everything possible done to prolong my life, even if I were in a permanent coma: _____

HEALTH HABITS / SOCIAL HISTORY

	Currently	Quit Date
Caffeine:	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Tobacco:	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Alcohol:	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____
Illicit Drugs:	<input type="checkbox"/> YES <input type="checkbox"/> NO	_____

- Have you ever felt you should cut down on your drinking?
 YES NO
- Have people annoyed you by criticizing your drinking?
 YES NO
- Have you ever felt bad or guilty about your drinking?
 YES NO

Have you ever had a drink first thing in the morning to calm your nerves or get rid of a hang-over? YES NO

Are you sexually active? YES NO

FAMILY HEALTH HISTORY

Check (✓) if you or your blood relatives have or have had any of the following:

Disease	You	Family	Relation to
Alcohol / Drug dependency			
Asthma/ Chronic Lung Disease			
Cancer			
Diabetes			
Heart Disease			
High Blood Pressure			
Kidney disease			
Mental illness or Depression			
Migraines			
Peptic Ulcer			
Seizures			
Stroke			
Thyroid trouble			
Tuberculosis			
Other			