Name:________________________ Place of birth:____________________ Do you have children?_____ How many?_________

SOCIAL HISTORY			ALLERGIES		REACTION
Do you smoke?	☐Yes. How much?_______	☐No	Aspirin	☐Yes ☐No	____________________________
Do you drink alcohol?	☐Yes. How much?_______	☐No	Narcotics	☐Yes ☐No	____________________________
Do you drink coffee?	☐Yes. How much?_______	☐No	Food(s)	☐Yes ☐No	____________________________
Do you take estrogen?	☐Yes. How much?_______	☐No	Others		____

FAMILY HISTORY

Mother Age___ ☐Deceased Problems: ☐Cancer, Type:___________ ☐High Blood Pressure ☐Diabetes ☐Stroke ☐Other: ________________

Father Age___ ☐Deceased Problems: ☐Cancer, Type:___________ ☐High Blood Pressure ☐Diabetes ☐Stroke ☐Other: ________________

Brothers(s) Problems: ☐Cancer, Type:___________ ☐High Blood Pressure ☐Diabetes ☐Stroke ☐Other: ________________

Sister(s) Problems: ☐Cancer, Type:___________ ☐High Blood Pressure ☐Diabetes ☐Stroke ☐Other: ________________

Other(s): ____

Have YOU had	YES	NO		YES	NO		YES	NO	**Please specify**
High blood pressure	☐	☐	Diabetes type I	☐	☐	Thyroid disease	☐	☐	Type:
Kidney disease (dialysis? Y/ N)	☐	☐	Diabetes type II	☐	☐	Heart condition	☐	☐	Type:
Polio	☐	☐	Asthma	☐	☐	Heart failure	☐	☐	Type:
Tuberculosis	☐	☐	COPD	☐	☐	Heart attack	☐	☐	Type:
Stroke / TIA	☐	☐	Corrective lenses	☐	☐	Blood transfusion	☐	☐	When:
Colitis	☐	☐		☐	☐	Cancer	☐	☐	Type:
Colon polyps	☐	☐		☐	☐		☐	☐	
Hepatitis	☐	☐		☐	☐		☐	☐	
Blood clots	☐	☐		☐	☐		☐	☐	

Are you currently taking any medications? ☐No ☐Yes (please list): ____

____

Have you ever had surgery? ☐No ☐Yes (please list): ____

____

List all serious injuries or illnesses that resulted in hospitalization (include dates): ______________________________

____

DO YOU HAVE ANY OF THE FOLLOWING SYMPTOMS FREQUENTLY? (circle all that apply)

Hot flashes	Chronic hoarseness	Vomiting of blood	Hemorrhoids	Ankle swelling
Headaches	Difficulty swallowing	Abdominal pain	Difficulty urination	Leg numbness
Night sweats	Ringing in the ears	Blood in stool	Frequent urination at night	Dizzy spells
Weight gain	Chronic cough	Abdominal swelling	Kidney infections	Fainting
Weight loss	Shortness of breath	Constipation	Back pain	Convulsions
Change in vision	Chest pain (angina)	Diarrhea	Neck pain	
Corrective lenses	Palpitations	Heartburn/indigestion	Leg cramping	

Height:_________________ Weight:_________________ How long have you been at this weight?: :_________________

WOMEN ONLY

Age at onset of menstruation ___________ Number of pregnancies ___________ Did you breastfeed? ___________

Date of last menstrual period___________ Are your periods regular? ___________ Are you pregnant? ___________