

The Following information is very important to your health. Please take the time to fully and accurately fill out this form.

Name: _____ DOB: _____

Any known allergies: _____

Current Medications: (prescription and OTC – please include dosage and how medication is taken)

Are you currently taking any of the following medications?

	Y	N		Y	N		Y	N
Aspirin			Laxatives			Birth Control Pills		
Herbal Supplements			Vitamins					

Please list any problems requiring hospitalization :(Include surgeries and childbirth)

Please list any diseases you have not requiring hospitalization (diabetes, asthma, etc.)

Female patients: Gynecologist: _____
 Date of last Mammogram: _____
 Date of last Pap: _____
 Menstrual History :(age at onset, regular or irregular, etc.) _____

Please list and note relation (parent, sibling, children, etc.) of any **family** history of:

Stroke:	Diabetes:	Heart Attack:
Cancer:(type)	Mental Health Problems:	High Blood Pressure:

Have you ever had a Pneumonia Vaccination? _____ Date: _____

Date of last Tetanus Shot: _____ Date of most recent Flu Vaccine: _____

What is your occupation? _____
 Do you have children? _____ If yes, how many? _____
 Who lives with you at home? _____
 Do you use tobacco products? _____ How many years? _____ How much? _____
 Do you consume caffeine? (coffee, tea soda, choc) _____ How much? _____
 Do you consume alcohol? _____ How much? _____
 Do you regularly exercise? _____ Frequency? _____

The above information is true and correct to the best of my belief

Signature: _____ **Date:** _____