

IDENTIFYING DATA				CURRENT IMMUNIZATION STATUS		
MEMBER NAME		DATE		TYPE	APPROX. DATE	HAVE HAD DISEASE
INS. PLAN		SS #		INFLUENZA		
SEX		MARITAL STATUS	DATE OF BIRTH	MUMPS		
OCCUPATION		PAST OCCUPATION		MEASLES		
PRIOR M.D.		DATE OF LAST EXAM		RUBELLA / GERMAN MEASLES		
<b>ALLERGIES/REACTIONS TO MEDICATION</b>				TETANUS		
				B.C.G.		
				PNEUMONIA VAC.		
				HEPATITIS B VAC.		
				OTHER		
				<b>SURGERIES / PROCEDURES:</b>		<b>YEAR</b>
1						
2						
3						
4						
5						
6						
<b>MEDICATION: PRESCRIBED AND NON-PRESCRIBED</b>				<b>ACCIDENTS / INJURIES</b>		
DRUG NAME	DOSE	TAKEN HOW OFTEN				
1						
2						
3						
4						
				<b>SOCIAL</b>		
				# OF CAFFEINE CUPS/DAY		
				TOBACCO: # PACKS/DAY		
				STRESS (HIGH, MEDIUM, LOW)		
				LIFESTYLE/WORK FACTORS THAT INFLUENCE HEALTH		
				TOXIC OCCUPATIONAL EXPOSURE		
				DO YOU WEAR SEAT BELTS?		
				HABITUAL ALCOHOL USE?		
				HOW MUCH?		
				HABITUAL DRUG USE?		
				TYPE & HOW MUCH?		
<b>FAMILY HISTORY: (PLEASE INDICATE ANY BLOOD RELATIVE WITH HISTORY OF THE FOLLOWING)</b>						
CANCER			STROKE			
HIGH CHOLESTEROL			ALZHEIMER'S			
LEUKEMIA			BLEEDING PROBLEMS			
DIABETES			EMPHYSEMA			
HIGH BLOOD PRESSURE			ALCOHOLISM			
HEART DISEASE			MENTAL ILLNESS			
HEART ATTACK			OTHER HEREDITARY DISEASES			
SUDDEN DEATH						

**WHAT SERIOUS MEDICAL CONDITION OR DISEASE DO YOU HAVE OR HAVE HAD PREVIOUSLY**

	YES	NO		YES	NO
HEADACHES (FREQUENT)			ANEMIA		
EYE PROBLEMS			WEIGHT GAIN / LOSS		
FAILING VISION			CANCER		
HEARING LOSS					
HIGH BLOOD P			TB		
THYROID DISEASE			PNEUMONIA / PLEURISY		
STROKE			VALLEY FEVER		
DIZZY OR FAINT					
CONVULSIONS / SEIZURES			BLOODY OR BLACK STOOLS		
HAY FEVER			JAUNDICE / HEPATITIS		
HIVES / RASHES			GALL BLADDER TROUBLE		
TONSIL PROBLEMS			DIARRHEA		
EMPHYSEMA			CONSTIPATION		
ACNE			FREQ. ABDOMINAL PAIN		
			CHANGE IN BOWEL HABITS		
PERSONAL HISTORY OF HEART ATTACK			INDIGESTION / HEARTBURN		
CHEST PAIN			PEPTIC ULCERS		
HEART DISEASE					
IRREGULAR HEART BEAT			URINATE AT NIGHT >2 TIMES		
HEART MURMUR			LEAKING URINE		
RHEUMATIC FEVER			URINARY TRACT		
SHORTNESS OF BREATH			INFECTIONS		
HIGH CHOLESTEROL			KIDNEY STONES		
HIGH BLOOD PRESSURE			PAINFUL URINATION		
OBESITY			BLOOD IN URINE		
DIABETES					
UNUSUALLY THIRSTY			VENEREAL DISEASE		
SWOLLEN ANKLES			INFERTILITY		
			IMPOTENCE		
GOUT			<b>FOR FEMALES ONLY</b>		
VARICOSE VEINS			PAINFUL MENSES / PERIODS		
MAJOR INJURIES			VAGINAL SPOTTING		
ARHTRITIS			BLEEDING AFTER MENOPAUSE		
BROKEN BONES			IRREGULAR MENSES / PERIODS		
JOINT INJURIES			DID YOUR OTHER TAKE A HORMONE		
SCOLIOSIS			(DES) DURING PREGNANCY WITH YOU?		
LEG PAIN WHEN WALKING			DO YOU DO SELF BREAST EXAMS?		
BACK PAIN			METHOD OF BIRTH CONTROL		
			LAST PAP SMEAR NORMAL?		
SLEEPING DIFFICULTY			# OF PREGNANCIES		
MENTAL DISORDER			# OF CHILDBIRTHS		
DEPRESSION			# OF MISCARRIAGES		
NERVOUSNESS			# OF ABORTIONS		
HABITUAL ALCOHOL USE			DATE OF LAST MAMMOGRAM	ABN. <input type="checkbox"/>	NORMAL <input type="checkbox"/>
HABITUAL DRUG USE			DATE OF LAST PAP SMEAR	<input type="checkbox"/>	<input type="checkbox"/>
<b>COMMENTS / CURRENT CONDITION</b>					
HAVE YOU COMPLETED AN ADVANCED DIRECTIVE OR LIVING WILL <input type="checkbox"/> YES <input type="checkbox"/> NO					
REVIEWED BY:			M.D.	DATE:	

★★★ SEE OTHER SIDE ★★★