MEDICAL HISTORY

CONDITION	YEAR	CONDITION	YEAR
ALCOHOL/DRUG ABUSE		HIGH CHOLESTEROL	
ALLERGIC RHINITIS		HIV/AIDS	
ANEMIA		HYPOTHYROIDISM	
ANXIETY		HYPERTHYRODISISM	
ASTHMA		IRREGULAR HEARTBEAT	
ATRIAL FIBRILLATION		IRRITABLE BOWEL DISEASE	
AUTOIMMUNE DISORDER		LIVER DISEASE	
BACK PAIN		LUPUS	
BENIGN PROSTATIC HYPERTROPHY		KIDNEY FAILURE/INSUFFICIENCY	
BLEEDING DISORDER		MIGRAINE HEADACHES	
BLADDER INFECTIONS		MYOCARDIAL INFARCTION	
BLOOD CLOTS		OSTEOARTHRITIS	
BONE FRACTURES		OSTEOPOROSIS/OSTEOPENIA	
BREAST CANCER		OVARIAN OR ENDOMETRIAL CANCER	
CANCER-TYPE		PERIPHERAL VASCULAR DISEASE	
CATARACTS		POLIO	
CIRRHOSIS		PROSTATE CANCER	
COLON CANCER		PULMONARY EMBOLSIM (PE)	
COLON POLYPS		RHEUMATIOD ARTHRITIS	
COPD		SCIATICA	
CORONARY ARTERY DISEASE		SCOLIOSIS	
CROHNS DISEASE/ULCERATIVE COLITIS		SEXUALLY TRAMSMITTED DISEASE	
COPD/EMPHYSEMA		SEIZURES	
CHRONIC BRONCHITIS		SCOLIOSIS	
DEPRESSION		SEXUALLY TRAMSMITTED DISEASE	
DEGENERATIVE DISC		SEIZURES	
DIABETES		SICKLE CELL DISEASE/TRAIT	
DVT		SKIN CANCER	
FIBROMYALGIA		STROKE	
GERD (REFLUX)		THYROID CANCER	
GOUT		THYROID NODULES	
HEPATITIS A/B/C		TUBERCOLOSIS	
HERNIATED DISCS		OTHER	
HIGH BLOOD PRESSURE		OTHER	
		OTHER	

STAFF MEMBER INT:________________

MEDICAL HISTORY

DIAGNOSTICS			DATE
DEXA	YES	NO	
COLONOSCOPY	YES	NO	
MAMMOGRAM	YES	NO	
PROSTATE EXAM	YES	NO	
FLU SHOT	YES	NO	
PNEUMONIA SHOT	YES	NO	
TETNAS SHOT	YES	NO	
LAST MENSTRAL PERIOD			

TYPES OF SURGIES:

TYPE OF SURGERY	YEAR	HOSPITAL AND/OR SURGEON	OUTCOME

CURRENT MEDICATIONS: (PRESCRIPTION AND OVER THE COUNTER)

MEDICATION	STRENGTH	HOW MANY TIMES PER DAY?

DRUG ALLERGIES

MEDICATION	REACTION (HIVES, NAUSEA, ETC.)	MEDICATION	REACTION (HIVES, NAUSEA, ETC.)

STAFF MEMBER INT:_______________

SOCIAL HISTORY

Occupation	☐ full-time ☐ part-time ☐ retired ☐ disabled ☐student ☐ unemployed
Highest Level Of Education	☐ high school diploma ☐ some college ☐ college graduate
Do you have any Barriers to Learning?	☐ vision ☐ reading ☐ language ☐ hearing
Preferred Language	☐ English ☐ Spanish ☐ other
Marital Status	☐ single ☐ married ☐ partner ☐ separated ☐ divorced ☐widowed
Race (Optional)	☐ white ☐ black/African American ☐ Hispanic ☐ other
Ethnicity (Optional)	☐ Hispanic/Latino ☐not Hispanic/Latino ☐other
Do you have an Advanced Directive or Living Will?	☐ yes ☐ no
Do you have a legal guardian or Healthcare Power of Attorney?	☐ yes ☐ no if so, whom______________________
Do you currently smoke cigarettes?	☐ yes ☐ no packs per day _________ years smoked _________
Are you a former smoker?	☐ yes ☐ no
Do you use other forms of tobacco?	☐ yes ☐ no ☐ pipe ☐ cigar ☐ snuff ☐chew
Are you exposed to smoke at home at home or work?	☐ yes ☐ no
Do you drink alcohol?	☐ Yes ☐no ☐ beer ☐ wine ☐ liquor How many drink a day? _______
Do you use marijuana or recreational drugs?	☐ yes ☐no
Do you exercise regularly?	☐ Yes ☐ no If so what type and how often? ____________________________________
How would you describe your diet?	☐ healthy ☐ low carb ☐ low fat ☐ unhealthy ☐vegetarian ☐ vegan
How often do you use caffeine?	☐ yes ☐ no ☐ chocolate ☐ soda ☐ tablets ☐ coffee ☐tea ☐energy drinks or shots ☐ other How much do you use? _____________________

STAFF MEMBER INT:_______________