



## Medical History

Date \_\_\_\_\_

### Please List and Supply the Dates of:

Operations \_\_\_\_\_

Hospitalizations other than for surgery \_\_\_\_\_

Immunization history—have you had: Please Circle if yes.

.Hepatitis A, Hepatitis B, Pneumonia vaccine, MMR, Tetanus HPV (Gardasil) Chickenpox Meningitis Herpes Zoster

When was your last:

Pap Smear? \_\_\_\_\_ Breast Exam? \_\_\_\_\_ Colon Cancer Test? \_\_\_\_\_

Mammogram? \_\_\_\_\_ Cholesterol check? \_\_\_\_\_ Prostate exam? \_\_\_\_\_

### Family History

Has any member of your family (parents, grandparents, and siblings) ever had the following?

Illness	Which family member?	Age when diagnosed
Cancer (describe type)	_____	_____
Hypertension (high blood pressure)	_____	_____
Heart Disease	_____	_____
Diabetes	_____	_____
Strokes	_____	_____
Mental disease (anxiety, depression)	_____	_____
Drug or alcohol addiction	_____	_____
Glaucoma	_____	_____
Bleeding diseases	_____	_____
Other _____	_____	_____

### Medications (Prescription, Over-the-Counter, Vitamins, Herbs, etc.)

Drug Name	Dose	Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

### Prevention

Do you exercise regularly?  Yes  No If yes, type, duration and number of times per week? \_\_\_\_\_

Did you /do you smoke?  Yes  No If yes, how many packs per day? How long? \_\_\_\_\_

Do you drink alcoholic beverages?  Yes  No If yes, how much per week? \_\_\_\_\_

Do you drink coffee or tea  Yes  No If yes, how many cups per day? \_\_\_\_\_

Do you use drugs? (marijuana, cocaine, etc)  Yes  No If yes, explain: \_\_\_\_\_

Have you ever engaged in any activity which has put you at risk of getting AIDS?  Yes  No If yes, explain: \_\_\_\_\_

Do you wish to be tested for AIDS?  Yes  No

Method of birth control? \_\_\_\_\_