



Name: _____

Page Begun: _____ Birthdate: _____

Hosp. / Injuries / Surgery (year onset)

Chronic Medical Illnesses (year onset)

Med. Allergies / Adv. Effects

Drug	Adverse Response
_____	_____
_____	_____
_____	_____
_____	_____

Family History Parent, Sibs, Offspring; age

Cancer (site) _____
Cor. Heart Disease _____
Stroke _____
HTN _____
Obesity _____
Diabetes _____
Mental Illness _____
Subs. Abuse _____
Other _____

Social History

Needs interpreter? ___ Other language: _____
 Tobacco: Form _____ Pack-Yrs: _____
 Quitting? Year _____
Work: _____ Hazards: _____

 EtOH at-risk EtOH behaviors
 Street drugs Injected
 Hx STD's Home / housing safety issues

Specialty / Off-site Care Type, name, date

Mental Health _____
GYN _____

Cancer Screening (mo/yr)

Pap _____
Mammog. _____ Hght: _____
Colon _____
Prostate _____

Vaccinations (mo/yr)

Flu _____
Pneumovax _____ PPD: _____
Hep B ?Complete Hep A ?Complete
Tdap _____ Tet. / Diphth. _____

