

**Personal Health Information**

Name \_\_\_\_\_

Date \_\_\_\_\_ Date of Birth \_\_\_\_\_ Age \_\_\_\_\_

**List all medications** you take including any supplements or over the counter drugs:

Name of Drug	Dose (if known)	How Often

Please list any drug or food **allergies** \_\_\_\_\_

**Your Medical History** – Please mark if you have or have ever had any of the following diseases

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Cancer<br>Type: _____ | <input type="checkbox"/> Heart Attack           | <input type="checkbox"/> Stroke                |
| <input type="checkbox"/> Chest Pain            | <input type="checkbox"/> Heart Failure          | <input type="checkbox"/> Thyroid Problems      |
| <input type="checkbox"/> Diabetes              | <input type="checkbox"/> High Blood Pressure    | <input type="checkbox"/> Ulcer                 |
| <input type="checkbox"/> Endometriosis         | <input type="checkbox"/> Irregular Heartbeat    | <input type="checkbox"/> Mitral Valve Prolaspe |
| <input type="checkbox"/> Spastic Colon         | <input type="checkbox"/> Kidney Stones          | <input type="checkbox"/> Glaucoma              |
|  | <input type="checkbox"/> Lung Disease/Emphysema |  |

Any **Hospitalizations**? Please note date and reason: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Your Surgical History** – Please mark if you have had any of the following surgeries

- |                                       |  |                                       |  |
|---------------------------------------|--|---------------------------------------|--|
| <input type="checkbox"/> Angioplasty  | <input type="checkbox"/> Heart By-Pass | <input type="checkbox"/> Kidney       | <input type="checkbox"/> Prostate      |
| <input type="checkbox"/> Back Surgery | <input type="checkbox"/> Heart Valve   | <input type="checkbox"/> Kidney Stone | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Bladder      | <input type="checkbox"/> Hernia        | <input type="checkbox"/> Ovary        | <input type="checkbox"/> Tonsils       |
| <input type="checkbox"/> Gall Bladder | <input type="checkbox"/> Hysterectomy  | <input type="checkbox"/> Pacemaker    |  |

**Other Surgery** – Please specify \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



**Urinary:**

Difficulty Urinating	Yes___	No___	Urinary Incontinence	Yes___	No___
Painful Urination	Yes___	No___	Blood in Urine	Yes___	No___
Increased Frequency	Yes___	No___			

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**Genital/Reproductive:**

Sexual Problems	Yes___	No___	Currently Pregnant (Female)	Yes___	No___
Decreased Sexual Drive	Yes___	No___	Abnormal Menstrual Periods	Yes___	No___

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**Musculoskeletal:**

Leg Cramps	Yes___	No___	Leg Cramps with Walking	Yes___	No___
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**Skin:**

Rash	Yes___	No___	Concerning Skin Lesions	Yes___	No___
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**Neurologic:**

Headaches	Yes___	No___	Tremors	Yes___	No___
Fainting	Yes___	No___	Memory Loss	Yes___	No___

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**Mental Status:**

Anxiety	Yes___	No___	Bi Polar Disorder	Yes___	No___
Depression	Yes___	No___	Schizophrenia	Yes___	No___

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**Endocrine:**

Weight Gain	Yes___	No___	Post Menopausal (Female)	Yes___	No___
Weight Loss	Yes___	No___	Hot Flashes	Yes___	No___
Thyroid Problems	Yes___	No___			

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**Hematologic:**

Abnormal Bruising	Yes___	No___	Immune Deficiency	Yes___	No___
Abnormal Bleeding	Yes___	No___	Sickle Cell Disease or Trait	Yes___	No___
Anemia	Yes___	No___	Lupus	Yes___	No___
Trouble with Blood Clotting	Yes___	No___	Hepatitis C	Yes___	No___
Previous Transfusions	Yes___	No___	HIV	Yes___	No___