HISTORY INTAKE FORM

Patient Name_____ D.O.B._____Sex____

Height_____ Weight_____ Occupation_____
Smoking Y N type _____ how much_____ how long_____quit(when)____
Alcohol Y N type_____how much_____how long_____quit(when)____

Drug Allergies N.K.A. or known_____
_____

List previous surgeries or major illnesses and dates _____
_____
_____

List any medications you are taking including non-prescription and vitamins_____
_____
_____

Family History (any blood relative) please state which relative and if they are deceased due to their disease process
S=sister B= brother M= mother F= father U = uncle A = aunt MGM= mom's mom MGF= mom's dad FGM =father's mom and PGF= father's dad

Cancer	Y	N	who?_____	when_____
Heart Disease	Y	N	who?_____	when_____
Stroke	Y	N	who?_____	when_____
High Blood Pressure	Y	N	who?_____	when_____
Kidney Disease	Y	N	who?_____	when_____
Depression	Y	N	who?_____	when_____
Skin conditions	Y	N	who?_____	when_____
Diabetes	Y	N	who?_____	when_____

Your Past Medical History Have ever had one of the following?

Heart Disease. .	Y N	Glaucoma.	Y N	Stomach Ulcer .	Y N
Arthritis. .	Y N	Asthmas .	Y N	Kidney Disease .	Y N
Rheumatic Fever. .	Y N	Aids or HIV .	Y N	Stroke .	Y N
Anemia. .	Y N	Melanoma	Y N	Skin Cancer .	Y N
Tuberculosis. .	Y N	Thyroid disease.	Y N	Bleeding disorder .	Y N
Diabetes. .	Y N	Mitral Valve .	Y N	High Blood Pressure .	Y N
Hepatitis. .	Y N	Skin Lesions .	Y N	Breast Cancer .	Y N
Prostate Cancer	Y N	neurological .	Y N	Tumors .	Y N

Last menstrual cycle_____ Last PAP Sear_____ Last prostate exam