

TODAY'S DATE : _____

INFORMATION FOR YOUR PHYSICIAN

Please answer the following questions prior to your first examination.

It will help your physician to know not only about your health, but also about your family's health history.

NAME _____ ADDRESS _____

CITY _____ STATE _____ ZIP CODE _____

TELEPHONE NUMBER _____ DATE OF BIRTH _____ AGE _____

SEX : M F MARITAL STATUS: Single Married Widowed Separated Divorced

EMPLOYER _____

OCCUPATION _____ BUSINESS PHONE _____

EMERGENCY CONTACT _____ EMERGENCY PHONE _____

HEALTH HISTORY

	FATHER	Present health or cause of death	MOTHER	Present health or cause of death
ALIVE	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____
DECEASED	<input type="checkbox"/>	_____	<input type="checkbox"/>	_____

	SPOUSE	Present health or cause of death
ALIVE	<input type="checkbox"/>	_____
DECEASED	<input type="checkbox"/>	_____

CHILDREN	No. ALIVE	Present health	No. DECEASED	Cause of death
	_____	_____	_____	_____
		_____		_____

BROTHERS	No. ALIVE	Present health	No. DECEASED	Cause of death
	_____	_____	_____	_____
		_____		_____

SISTERS	No. ALIVE	Present health	No. DECEASED	Cause of death
	_____	_____	_____	_____
		_____		_____

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES: Diabetes
 Cancer Bleeding Tendency Kidney disease Tuberculosis Heart disease Stroke
 High blood pressure Nervous Illness Allergy Other _____

CHECK ANY ILLNESSES OR CONDITIONS YOU HAVE HAD: Diabetes Glaucoma
 Heart trouble Syphilis Vein trouble Cancer Asthma Jaundice Gonorrhoea
 Bleeding tendencies Tuberculosis Pneumonia Kidney Disease Rheumatic Fever
 Nervous disorder Other _____

LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC.?

No Yes - LIST: _____

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES?

No Yes - LIST: _____

DO YOU USE TOBACCO NOW? No Yes - TYPE AND DAILY AMOUNT _____

IN THE PAST? No Yes - TYPE AND DAILY AMOUNT _____

DO YOU DRINK ALCOHOLIC BEVERAGES? TYPE WEEKLY AMOUNT HOW LONG?
 No Yes _____

DO YOU DRINK COFFEE? No Yes

CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED

Smallpox Tetanus Typhoid Polio Influenza Hepatitis B Pneumonia
 Other _____

PREVIOUS OPERATIONS (Dates, hospitals and name of surgeon)

DENTAL (List any problems you have now)

MEDICATIONS (Name or otherwise identify medicines now or recently used)

ONSET DATE OF LAST MENSTRUAL PERIOD _____ **PERIODS ARE? :** Regular Irregular

NUMBER OF PREGNANCIES _____ **NUMBER OF MISCARRIAGES** _____

HAVE YOU TAKEN CORTISONE-TYPE DRUGS? Yes No **ORAL CONTRACEPTIVES?** Yes No

HAVE YOU RECEIVED A BLOOD TRANSFUSION? Yes - Date _____ No

DRESSED WEIGHT _____ **HOW LONG HAVE YOU BEEN AT THIS WEIGHT?** _____

WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT? _____

WHAT IS YOUR MAIN SYMPTOM? _____

Reviewed By (Physician) _____ Date : _____