

Past Medical History/Conditions/Disease. Please check all that apply.

Unremarkable		Crohn's Disease		Hepatitis A		Thyroid Disorder
Asthma		Chronic Renal Failure		Hepatitis B		Tuberculosis
Atrial Fibrillation		Depression		Hepatitis C		Valvular Heart Disease
Anemia		Diabetes, Type 1		Infertility		UTI-Recurrent
Anxiety Disorder		Diabetes, Type 2		Kidney Disease		Varicose Veins/ Phlebitis
Autoimmune Disorder		Diverticulitis		Kidney Stone		Abnormal Pap Smear
Biliary Cirrhosis		DVT (blood clot)		Liver Disease		Breast Disease
Blood Transfusions		GI Bleeding		MI (heart attack)		Breast Cancer
Brain Tumor		GERD (acid reflux)		Neurologic Disorder		Cervical Cancer
Cerebrovascular Disease		Hemochromatosis		Osteoarthritis		DES Exposure
Cirrhosis		Hyperlipidemia		Osteoporosis		Gestational Diabetes
CVA/Stroke		Hypertension		Peripheral Vascular Disease		RH Sensitized
COPD		Hypothyroidism		PUD		Total Abdominal Hysterectomy
Colon Cancer		Hyperthyroidism		Rheumatoid Arthritis		TAH and BSO
Coronary Heart Disease		Seizure Disorder		Uterine Anomaly		

Surgical History

Surgeries / Hospitalizations	Year	Complications (if any)

General Medical History Form

Name: _____

DOB: _____

Family History. Has anyone in your family had (check all that apply):

	Alcoholism		Anemia		Arthritis		Anesthesia Complications
	Anxiety		Asthma		Birth Defects		Blood Clots
	Blood Transfusions		Breast Cancer		Cervical Cancer		Colon Cancer
	Depression		Diabetes		Growth/ Development Disorder		Heart Attack
	Angina (chest pains)		High Blood Pressure		High Cholesterol		Mental Illness
	Osteoporosis		Seizure Disorders		Severe Allergies		Stroke
	Suicide Attempt		Bowel Disease		Heart Disease		Kidney/Bladder Disease
	Lung/Respiratory Disease		Liver Disease		Sexually Transmitted Disease		Ulcers
	Coronary Heart Disease Male before age 55		Coronary Heart Disease Female before age 65		Colon Cancer Father		Colon Cancer Mother
	Lung Cancer		Melanoma				

Other: _____

Social History (check all that apply):

	Current Smoker
	Former Smoker
	Never Smoked
	Passive cigarette smoke—Yes
	Passive cigarette smoke—No

	Alcohol use—Yes
	Alcohol use—No
	Drug use—Yes
	Drug Use—No

	HIV/High risk—Yes
	HIV/High risk—No

	Regular exercise—Yes
	Regular exercise—No

	Domestic Abuse
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Vaccination History

Last pneumonia shot date	
Last flu shot date	