Patient Name: _____ **Date of Birth:** _____ **Date:** _____

MEDICATIONS AND DOSAGE (including aspirin and over the counter medications or provide separate list)

MEDICATION NAME	DOSAGE	MEDICATION NAME	DOSAGE

Allergies and Reactions: _____

_____

CHIEF COMPLAINT—Why are you here today? _____

_____

ADVANCED DIRECTIVE/ LIVING WILL? ☐Yes ☐No

PATIENT PRIOR HOSPITALIZATIONS	**WHEN?**	**PRIOR SURGERIES/OFFICE PROCEDURES**	**WHEN?**

PATIENT SOCIAL HISTORY

Smoker? ☐Yes ☐No
How many packs daily? _____
How many years? _____
Interested in stopping? ☐Yes ☐No
Do you smoke Marijuana? ☐Yes ☐No

Alcohol Drinker ☐Yes ☐No
Type _____
Amount _____

Trouble sleeping? ☐Yes ☐No
Do you snore? ☐Yes ☐No
Daytime drowsiness ☐Yes ☐No

Coffee Drinker ☐Yes ☐No
How many cups daily? _____
Other caffeine? _____

Female Patients Only:
Pains or cramps: ☐Yes ☐No
Regular Periods: ☐Yes ☐No ☐Varies
Complications w/ pregnancy: ☐Yes ☐No
How many Cesarean Sections: _____
How many children born alive: _____
How many miscarriages: _____
Have you had a hysterectomy: ☐Yes ☐No
Are you pregnant: ☐Yes ☐No
Last Menstrual Period: _____
Date of Last Mammogram:

PATIENT MEDICAL HISTORY

ARTHRITIS	☐Yes ☐No	KIDNEY DISEASE	☐Yes ☐No
CANCER	☐Yes ☐No	MENTAL ILLNESS	☐Yes ☐No
DIABETES	☐Yes ☐No	THYROID DISEASE	☐Yes ☐No
HEART DISEASE	☐Yes ☐No	STROKE	☐Yes ☐No
HYPERTENSION	☐Yes ☐No	DATE OF LAST COLONOSCOPY:	_____

FAMILY MEDICAL HISTORY

Condition	Father	Mother	Father's Parents	Mother's Parents	Siblings	Age Deceased
Heart Disease						
Hypertension						
Stroke						
Cancer (indicate type)						
Diabetes						
Kidney Disease						
Thyroid Disease						
Crohn's Disease						
Diverticulitis/losis						