

Patient Name: \_\_\_\_\_ DOB \_\_\_\_\_



**Illnesses**

Indicate if you or a member of your family has had any of the following illnesses currently or in the past.

Condition	You	Who in your family	Cause of death and age at death
Alcoholism			
Alzheimer's			
Anemia			
Arthritis			
Asthma			
Back Injury			
Blood Transfusion			
Bowel Problems			
Breast Disease			
Bronchitis, severe			
Burns, severe			
Cancer			
Colitis			
Depression			
Diabetes			
Emphysema			
Fractures, major			
Gall bladder problems			
Glaucoma			
Gout			
Head Injury			
Heart attack/disease			
Heart murmur			
Hepatitis			
High blood pressure			
High cholesterol			
Kidney problems			
Lupus			
Menstrual problems			
Mental health			
Migraine			
Obesity			
Osteoporosis			
Phlebitis			
Pneumonia			
Prostate disease			
Recurrent UTI			
Rheumatic fever			
Seizure disorder			
Sexually transmitted dz			
Stomach ulcer/problems			
Stroke			
Suicide			
Thyroid			
Tuberculosis			
Valley fever			
Other			

Indicate surgeries you have had previously, if any

	Year		Year		Year		Year
Appendix		Hysterectomy		Eye		Kidney	
Bone & Joint		Gastro-intestinal		Hernia		Prostate	
Breast		Gall bladder		Heart		Other	

**Hospitalizations**

Conditions	Year	Details

**List current medications and dose including over the counter drugs and herbs**


**Allergies**


**Social history**

How many years have you lived in Arizona? \_\_\_\_\_ Where did you live prior to moving to Arizona and for how long?

Marital status (circle) Married Single Divorced Widowed

List your household members/children \_\_\_\_\_

List your pets \_\_\_\_\_

Do you have a living will?		Do you travel outside the U.S?	
When was your last:		When was your last:	
Mammogram?		Colonoscopy?	
Pap Smear?		Physical?	
DEXA scan?		Cholesterol check?	

			How much?
Do you exercise?			
Do you drink alcoholic beverages?			
Do you smoke?			
Do you drink caffeinated beverages?			
Do you use illegal drugs?			

The following is applicable to women only

Menstrual History					
Days between menses?	Duration of menses?	Flow: heavy, medium, light?	Age at onset of menses?		
Any pain or cramping?	Date of onset of last period?	Contraception method?			
Pregnancies					
# of pregnancies	Live births	Still births	Miscarriages	Abortions	C-sections
Births					
Year	Gestation	Delivery Type	Complications?	Weight	Sex

This is a confidential record of your medical history and will be made a permanent part of your medical record. Information will not be released except when you have authorized us to do so. Requires a separate consent for release of information.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date