Name: _____ DOB: _____

Reason for todays visit: _____

Please list all allergies to food, medication, or tap/laxtex and reaction:

Allergen	Reaction	Date

Past Medical History:

Past Surgical History:

Date	Procedure	Surgeon

Family History (Please list Relationship & Medical Condition):

Disease That Run in the Family	Cancers That Run In The Family

Social History:

Alcohol Use (Please Circle One)
Never Current Former Social
Amount Consumed Per Day: _____
Age Started: _____
Age Stopped: _____

Tobacco Use (Please Circle One)
Never Current Former
Amount Used Per Day: _____
Age Started: _____
Age Stopped: _____

Recreational Drug Use (Please Circle One)
Never Current Former
Drug: _____

Current Medications:

Medication/Reason for Taking	Dose	Times Taken per Day

Women Only

Age of first period: _____
Is there a possibility you could be pregnant? Yes ☐ No ☐
Number of pregnancies: _____ Full Term: _____ Miscarriages: _____ C-Section: Yes ☐ No ☐
Age of menopause: _____