

Patient Name _____ Date of Birth _____

MEDICAL CONDITIONS

(CURRENT AND PREVIOUS)

Condition/Diagnosis	Age and Date Diagnosed

ALLERGIES/SENSATIVITIES TO MEDICATIONS OR OTHER SUBSTANCE

Medication	Reaction

CURRENT MEDICATIONS AND DOSAGES

(INCLUDE OVER THE COUNTER MEDICATIONS/VITAMINS/SUPPLEMENTS)

Medication	Strength	Directions

SURGERIES/HOSPITALIZATIONS

Type/Reason	Age/Year

FAMILY MEDICAL HISTORY

	Age	Medical Condition/Disease/Diagnosis or Cause of Death
Mother		
Father		
Sister(s)		
Brother(s)		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		

SOCIAL HISTORY

Who lives in your household?

Name	Age	Relationship

How long have you lived in Arizona?	
What are your outside interests/hobbies?	

HEALTH HABITS

Do you smoke or chew tobacco?	When did you start?	
Did you ever smoke or chew tobacco?	When did you quit?	
How much do/did you smoke or chew?		

Do you drink alcohol?	How many drinks during a typical week?
Do you currently use non-prescribed medications or street drugs?	If yes, what:
Have you been treated for alcohol or substance abuse?	If yes, what:

Do you use a seat belt?	
Are you sexually active?	
Outside of work, do you engage in physical activity on a regular basis?	How many days per week? How many minutes per day?

HEALTH MAINTENANCE

When was your last physical exam?	When was your last blood work?
WOMEN: Date of last Pap Smear:	Date of last Mammogram?
Date of last Tetanus shot:	Date of last Flu vaccine:
Date of Pneumonia vaccine:	Date of Zostavax vaccine:

Do you have an Advance Directive (Living Will) in place?
Do you have a Medical Power of Attorney? If yes, list name(s):

Patient Name (Print) _____

Patient Signature _____

Date _____