Name: **Date of Birth:** **Today's date:**

Gender at Birth: **Gender Identity:** **Preferred Pronoun:**

all information provided on this form will be held in strict confidence, as is all of your medical record

FAMILY HISTORY: Please indicate whether there is a history of any of the following illness in your family by putting an X in the box following the illness.

Please explain who in your family had the illness and how they are related to you.

alcoholism		
allergic rhinitis		
asthma		
anemia		
bleeding tendencies		
cancer or tumor		
diabetes		
emotional problems		
glaucoma		
heart trouble		
high blood pressure		
high cholesterol		
mental illness		
obesity		
stroke		
tuberculosis		
other		

How many brothers do you have? How many sisters do you have?

How many children do you have? Daughters? Sons? please list their names and years of birth:

Deaths - If a close relative (parent, sister, brother) has died, write the cause of death and the age at death in the space provided.	

Give your age at onset for any of the following illnesses you have now or have had

	age		age		age		age		age		age
german measles		mumps		chickenpox		HIV or AIDS		eye disease		tuberculosis	
measles		polio		hepatitis		diverticulosis		meningitis		sexually transmitted	
mononucleosis		rheumatic fever		thyroid disease		emphysema		liver disease		disease? yes / no	

others not listed above

(OVER)

Name **Date of Birth** **Today's date**

please give the most recent date you've had the following tests:	PSA	prostate check	Pelvic / PAP	Breast Exam	mammogram	colonscopy	sigmoidoscopy	cholesterol check	general exam	do you have a health care proxy?
date										yes / no

Significant accidents & injuries:	type	at age	type	at age	type	at age	type	at age
type	at age	type	at age	type	at age	type	at age	

Surgeries including cesarean sections - please list with dates

Hospitalizations - please list with dates. Please include normal deliveries

Have you had any transfusions? yes/no - please list dates

Have you given birth to a baby weighing more than 9 pounds? yes / no

Have you had any complications of pregnancy? yes / no

# of pregnancies

SOCIAL HISTORY: please circle the answer to the following questions (fill in blanks where appropriate)

educational level completed: grade level_____ college degree_____, post grad_____, trade school _ marital status: divorced, married, single, separated, widowed

are you currently working? yes / no retired? yes / no year last worked type or field of work or study

are you the vicitm of abuse? If yes is it physical, emotional, sexual tobacco use: cigarettes, cigars, pipe, chew packs or number per day

alcohol use: none, rare, occasional, daily drugs: recreational, none, in past, currently caffeine: soda, coffee, tea number of cups per day

exercise: none, rare, regular, sporadic do you use sunscreen? yes / no do you use seat belts? yes / no

Sexual history: have you been sexually active in the past? yes / n age at first intercourse_____ number of partners in your lifetime, 0; 1-5; 5-10; >10

are you currently sexually active? yes / no do you use birth control? yes / no what method of birth control do you use?

: please give the date of your most recent	tetanus	flu shot	pneumovax	hepatitis B	other						
date											

do you have any allergies to medications? yes/no **Please list and explain**