



**Allergies**

<b>Allergen</b> <i>(Ex. Penicillin, shellfish, ragweed, etc)</i>	<b>Specific Reaction</b> <i>(Ex. Rash, anaphylaxis, gastro issues, etc)</i>

**Surgical History**

<b>Surgeries</b>	<b>Date</b>	<b>Description</b>
Tonsillectomy/adnoids		
Appendectomy		
Cholecystectomy		
Hysterectomy		
Tubal ligation		
Breast biopsy		
Joint replacement		
C-section		
Hernia		
Cataracts		
Other:		
Other:		

**Family Medical History**

\_\_\_\_\_ I am adopted.

	<b>Father</b>	<b>Mother</b>	<b>Siblings</b>	<b>Children</b>	<b>Other</b>	<b>Maternal Grandmother</b>	<b>Maternal Grandfather</b>	<b>Paternal Grandmother</b>	<b>Paternal Grandfather</b>
Age at Death									
Cause of Death									
Heart									
Diabetes									
Cancer (Type)									
Epilepsy									
Asthma									
Alive and Well									
Other:									

**Alcohol, Tobacco, Drug Use**

Current tobacco user: Former tobacco user:	Yes / No Yes / No	Cigarettes / Cigars / Chew Cigarettes / Cigars / Chew	Years of Use: Packs/ Amounts Per Day:
Do you drink alcohol?	Yes / No	Beer / Wine / Liquor	Servings Per Day: Servings Per Week:
Do you drink caffeine?	Yes / No	Coffee / Tea / Soda / Energy Drink	Per Day:
Any present illicit drug use?	Yes / No	Marijuana / Cocaine / Heroin / Rx / Other:	
Any past illicit drug use?	Yes / No	Marijuana / Cocaine / Heroin / Rx / Other:	
Do you exercise?	Yes / No	Type?	Per Week:
Do you wear your seatbelt?	Yes / No	Percent of Time:	
Do you have Advanced Directives in place?	Yes / No	Living Will / Durable Power of Attorney / Health Care Proxy / Advanced Directives	

### **Immunization History**

Please include your best estimate of the month and year you received the following immunizations.

Vaccine	Yes	No	Date of Most Recent
<b>Pneumonia:</b>			
<b>Influenza (Flu):</b>			
<b>COVID:</b>			
<b>Shingles:</b>			
<b>Tetanus:</b>			

**Health Screening History**

When was your....	Never or N/A	Date (mm/yyyy)	Results (if known)
<b>Last Colon Cancer Screening?</b>			
<b>Last Fasting Lab Draw?</b>			
<b>Last Prostate Blood Test?</b>			
<b>Last Bone Density Test?</b>			
<b>Last Mammogram?</b>			
<b>Last Pap Smear?</b>			
<b>Have you ever had a Hepatitis C screening?</b>			

**Have you ever had an HIV screening?** Circle: YES // NO // UNSURE