

Name: _____

Date of Birth: _____

Date: _____

ALLERGIES

(Use a separate sheet if more space is needed)

Substance of Medication	Reaction (What Happens)

SURGERIES (Operations)

What Operation?	Approximately When?

FAMILY HISTORY

List Health Problems

Mother	
Father	
Sisters (How many?)	
Brothers (How many?)	
Children (How many?)	

SOCIAL HISTORY

Tobacco Use?	What Type?	How Long?	When did you last Use?
Alcohol Use?	What Type?	How Much?	How Often?
Exercise	What Type?	How Long?	How Often?

OCCUPATION

What do you do now?	How long have you done it?
What have you done the longest?	How long did you do it?

IMMUNIZATIONS

Check any immunizations you had and give the approximate dates if you know them.

<input type="checkbox"/>	Influenza	<input type="checkbox"/>	Hepatitis A	<input type="checkbox"/>	Meningococcus
<input type="checkbox"/>	Pneumovax	<input type="checkbox"/>	MMR	<input type="checkbox"/>	Gardasil
<input type="checkbox"/>	Tetanus	<input type="checkbox"/>	Polio	<input type="checkbox"/>	Zostavax
<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>	Hemophilus	<input type="checkbox"/>	Other