NAME:____

Allergies: Medications Reaction

Other Allergies, food, environment, latex:

Medications Name Dosage

Past Surgeries Procedure Date/Year

Medical conditions/Problems Date of onset/Year

Known Family History/relationship

HTN	Cancers	Thyroid
DM	C.V.A	Osteoporosis
Heart Disease	Thrombosis	Hyper Lipidemia
Alzheimer's	Other____	

Total Pregnancies # Vaginal birth # Miscarriages # Living children #

Cesarean section # Year of births:

Current contraception:

Last Dental exam: **Last Mammogram:** **Last Pap Smear:**

Last eye exam: **Last Colonoscopy/Year:** **Last bone density scan:**

Vaccinations if known: **Last flu vaccine:** **Last tetanus vaccine:**

Smoke:_______________ # Cigarettes per day_______ # Years smoking___________________________

Alcohol:______________ # Drinks per week______________ Type____