

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

MEDICAL CONDITIONS (CURRENT AND PREVIOUS):	Age/Date Diagnosed
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

ALLERGIES (OR SENSATIVITIES) TO MEDICATIONS OR OTHER SUBSTANCE:	Type of Reaction
_____	_____
_____	_____
_____	_____

**CURRENT MEDICATIONS AND DOSAGES** (INCLUDE OVER THE COUNTER MEDICATIONS):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**VITAMINS, SUPPLEMENTS, HERBAL REMEDIES:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

SURGERIES/HOSPITALIZATIONS	Year/Reason
_____	_____
_____	_____
_____	_____

**FAMILY HISTORY** MEDICAL CONDITIONS OR CANCERS (If deceased give age and cause death):

Mother \_\_\_\_\_

Father \_\_\_\_\_

Brothers \_\_\_\_\_

Sisters \_\_\_\_\_

Maternal Grandmother \_\_\_\_\_

Maternal Grandfather \_\_\_\_\_

Paternal Grandmother \_\_\_\_\_

Paternal Grandfather \_\_\_\_\_

**Social History**

Who lives in your household? (List Name, Age, and Relationship) \_\_\_\_\_

How long have you lived in Arizona? \_\_\_\_\_

Outside Interests/Hobbies: \_\_\_\_\_

**Health Habits:**

Do you smoke or chew tobacco?  Yes  No  
When did you start/quit? \_\_\_\_\_

Did you ever smoke or chew tobacco?  Yes  No  
How much do/did you smoke? \_\_\_\_\_

Do you drink alcohol?  Yes  No If yes, how many drinks during a typical week? \_\_\_\_\_

Have you been treated for abuse of alcohol, prescription drugs or street drugs?  Yes  No

Do you currently use non-prescribed medications or street drugs?  Yes  No

Do you use a seat belt?  Yes  No

Are you sexually active?  Yes  No

Outside of work, do you engage in physical activity on a regular basis?  Yes  No

How many days a week do you exercise? \_\_\_\_\_ How many minutes? \_\_\_\_\_

**Health Maintenance:**

When was your last physical exam? \_\_\_\_\_

Women: Last Pap Smear \_\_\_\_\_

Last Mammogram \_\_\_\_\_

Tetanus-Date of last booster \_\_\_\_\_

Flu Vaccine-Date of last \_\_\_\_\_

Pneumonia Vaccine-Date given \_\_\_\_\_

Zostavax-Date given \_\_\_\_\_

Other Vaccinations and dates given \_\_\_\_\_

Please list names of other physicians/specialists you are currently seeing and conditions they are treating:

Do you have an Advanced Directive (Living Will) in place?  Yes  No

Do you have a Medical Power of Attorney? If yes, please list name(s): \_\_\_\_\_

**Patient Name (Print)** \_\_\_\_\_

**Patient Signature** \_\_\_\_\_

**Date** \_\_\_\_\_