Providers and Suppliers of Your Medical Care:

Please list all providers and suppliers of your medical care such as primary care physicians, specialty physicians, chiropractors, pharmacies, herbalists and therapists.

Primary Care Physician(s)	Specialty
Other Physicians	Specialty, Chiropractor, Pharmacies, Therapist ,

Current Medications:

Please include prescriptions, over-the counter medications, vitamins and supplements.

Medication name	Dose	Route	Frequency

Medication Allergies:

Medication	Reaction

DAILY ASPIRIN USE

Have you discussed taking a daily aspirin with your doctor?

___Yes

___No

Your History: Please check the appropriate box for the conditions as they apply to you:

Medical History

Condition	yes	no	Comments		Condition	yes	no	Comments		Condition	Yes	No	comments
Allergies					Depression					Heart Attack (Myocardial infarction)			
Anemia					Diabetes					Nerve/muscle disease			
Anxiety					Emphysema					Osteoporosis			
Arthritis					Reflux, Heartburn (GERD)					Seizures			
Asthma					Glaucoma					Sickle cell anemia			
Blood transfusion					Heart murmur					Stroke			
Cancer					HIV/AIDS					Substance abuse			
Cataracts					High Blood Pressure (Hypertension)					Thyroid disease			
Heart Failure (CHF)					Kidney disease					Tuberculosis			
Clotting disorder					Meningitis					Ulcers			
Chronic obstructive lung disease (COPD)													

Other Medical History:

Surgical History: Female

Surgery	Yes	No	Comments		Surgery	Yes	No	Comments		Surgery	Yes	No	Comments
Appendectomy					Cosmetic surgery					Joint replacement			
Brain surgery					C-Section					Small intestine surgery			
Breast Surgery					Eye surgery					Spine surgery			
Gall Bladder Surgery (Cholecystectomy)					Fracture surgery					Tubal Ligation			
Colon surgery					Hernia repair					Heart Valve Replacement			

Surgical History: Male

Surgery	Yes	No	Comments		Surgery	Yes	No	Comments		Surgery	Yes	No	Comments
Appendectomy					Cosmetic surgery					Prostate surgery			
Brain surgery					Eye surgery					Small intestine surgery			
Heart Bypass					Fracture surgery					Spine surgery			
Gall Bladder Surgery (Cholecystectomy)					Hernia repair					Heart Valve Replacement			
Colon surgery					Joint replacement					Vasectomy			

Other surgical history:

Family History: Please check the appropriate box of the conditions that apply to your blood relatives:

	Father	**Mother**	**Sister**	**Brother**	Aunt	Uncle	Daughter	**Son**
Alive								
Deceased								
Alcohol abuse								
Arthritis								
Asthma								
Birth Defects								
Cancer								
Chronic Obstructive lung disease (COPD)								
Depression								
Diabetes								
Drug Abuse								
Early Death								
Hearing Loss								
Heart Disease								
High Cholesterol								
Hypertension								
Kidney Disease								
Learning Disability								
Mental illness								
Mental Retardation								
Miscarriages								
Stroke								
Vision loss								

comments:

Social History:

Alcohol Use

___Yes____No

If Yes:____number of drinks per week

If Yes:________________________________type(s) of alcoholic beverages

Sexually Active

___Yes____No Not currently

If Yes: Circle appropriate responses

Partner(s): Male Female

If Yes: Birth control/Protection used________________

Drug Use

___Yes____No

If Yes:____number of times used per week

If Yes: list type(s) of recreational drugs used ____

Tobacco Use

___Yes ___No

Complete appropriate responses below:

____Current Every Day Smoker? ________Number of packs per day_________Number of Years

____Current Smoker? (not daily) ________Number of packs per week________Number of Years

____Former Smoker? ________Quit date

____Passive Smoker?

Are you ready to Quit?___Yes_____No

Smokeless Tobacco Use

___Yes ___No

Complete appropriate responses below:

____Former User? ________Quit date

____Never Used

Are you ready to Quit?___Yes_____N