Name: DOB: Date:

History of:	Yes	No
Chest Pain		
Coronary Artery Disease		
Cerebral Vascular Disease/Stroke		
Heart Attack		
High Blood Pressure		
History of Heart Failure		
TIA		
Cancer		
Respiratory Disorders		
Asthma		
COPD/ Emphysema		
High Cholesterol		
Diabetes - Type I		
Diabetes - Type II		
Anemia		
Other - Specify:		

History of:	Yes	No
Osteoarthritis		
Rheumatoid Arthritis		
Gout		
Hypothyroidism		
Hyperthyroidism		
Diverticulitis		
Irritable Bowel Syndrome		
Gastric Reflux Disease		
Atherosclerosis		
Morbid Obesity		
Kidney Disease		
Allergic Rhinitis/Allergies/Hayfever		
Anxiety		
Depression		
Dementia		
Fibromyalgia		

If YES to any above, who was/is the treating physician:

Language Preference	
Chinese ☐ English ☐ French ☐	
Japanese ☐ Spanish ☐ German ☐	
Greek ☐ Hindi ☐ Italian ☐	
Korean ☐ Sign Language ☐	
Communication Barrier	
Visual Impairment	☐
Left Eye	☐
Right Eye	☐
Blind	☐
Reported Hearing Problems	☐
Use of Hearing Aid	☐
Right Ear	☐
Left Ear	☐
Both Ears	☐
Deaf	☐
Healthcare POA (if yes need copy)	☐
Advanced Directives (if yes need copy)	☐

Procedures/Other	Doctor	Date	N/A
Mammogram			
Bone Density Study			
Osteopenia			
Osteoporosis			
Colonoscopy			
PAP Smear (women only)			
Menopause			
PSA (men only)			
ABI (Ankle Brachial Index)			
Eye Exam			
Dental Exam			
Cardiac Cath			
Stress Test			
ECHO			
Calcium Scoring Test			
Previous Hospitalizations			

Hospitalizations/Surgeries	Doctor	Date	N/A
Hysterectomy			
Cesarean Section			
Tubal Ligation			
Normal Vaginal Delivery (SVD)			
Cholecystectomy (Gall Bladder)			
Tonsillectomy			
Appendectomy			
Hip Replacement: Both R L			
Knee Replacement: Both R L			
Cataract Surgery			
CABG			
Other: Specify			
No prior Surgeries		Yes	No
Other Physicians you see:			

Family History	Good	Fair	ILL	Dec
Father				
Mother				
If deceased, at what age and due to what condition?				

Health Status of Siblings:		
Number Born		
Number Living		
All in Good Health	Yes	No
Father, Mother, and Siblings Only	Yes	No
Family History of Cancer		
Family History of Diabetes		
Family History of Heart Disease		
Family History of Kidney Disease		
Family History of Stroke		
Other Family History:		
If yes who is the family member and what is the problem?		

Personal/Social History		Check Appropriate Box
Marital History:	Currently Married	☐
	Single	☐
	Separated	☐
	Divorced	☐
	Widowed	☐
# Children Living:		
# of Miscarriages:		
Work History:	Working Full Time	☐
	Working Part Time	☐
	Retired	☐
	Unemployed	☐
Good Exercise Habits		☐
Alcohol Use		
Never ☐ Occasionally ☐ Currently ☐ Past Use ☐		
Family History of Alcohol		☐
Tobacco Use:		☐
How Much a Day?		
Drug Use:		☐
Other Personal/Social History		