Name _____ **Date of birth** _____ **Age** ____

Allergies: Are you allergic to penicillin or any other drugs? Please list:
What kind of reaction did you have?

Past Medical History:
Major illnesses:

Hospitalizations:

Surgeries:

Medications: Please list (with dosages and frequency taken):

_____ _____ _____
_____ _____ _____
_____ _____ _____

Social and Preventive History:
Do you currently smoke? Yes/No If no, have you in the past?
Do you drink alcohol, beer, or wine? Yes/No How many drinks/day or week:
Do you exercise regularly? Yes/No If yes, how many times/week?

Family History:

	Living	**Age (or age at death)**	**List serious illnesses**
Mother	Yes/No		
Father	Yes/No		
Sisters	Yes/No		
Brothers	Yes/No		

Has any member of your family had any of the following illnesses?

	Which family member?
Cancer (specify type)	_____
Diabetes	_____
Glaucoma	_____
Heart disease	_____
High blood pressure.	_____
Mental illness/depression	_____
Stroke	_____
Other serious illness	_____

Females: Gynecological History:
Have you been pregnant? _____ If yes, how many times? _____
Date of last Pap smear _____ Result: _____
Have you ever had an abnormal Pap smear? _____Diagnosis: _____ Follow-up: __