HISTORY CONTINUED:

Indicate if you have had the following, or mark as NA (not applicable)

Flu vaccine: □ Yes □ No Date: _____ Last Menstrual Period: Date: _____ □ NA
Tetanus shot: □ Yes □ No Date: _____ Mammogram: Date: _____ □ NA
Pneumovax: □ Yes □ No Date: _____ Chest x-ray: Date: _____ □ NA

Do you use tobacco products? □ Yes □ No □ Quit (when?) _____
Product: _____ Amount: _____ How Long: _____
Do you drink alcohol: □ Yes □ No □ Quit (when?) _____
Product: _____ Amount: _____ How Long: _____
Do you use street/other illicit drugs: □ Yes □ No □ Type/Quantity: _____
Do you use seat belts: ----------□Yes □No
Do you have children, do you use car safety seats: ----------□Yes □No
Within the last year, have you been hit, slapped, kicked or otherwise physically injured by someone □Yes□No
List any hazards associated with employment:_____
_____
Any other problems you have not previously listed: _____

FAMILY HISTORY:

Relation	Age	General Health/Diseases	If deceased, at what age and cause of death if known
Father	____	_____	_____
Mother	____	_____	_____
Brother(s)	____	_____	_____
	____	_____	_____
	____	_____	_____
Sister(s)	____	_____	_____
	____	_____	_____
	____	_____	_____
Spouse	____	_____	_____
Children	____	_____	_____
	____	_____	_____
	____	_____	_____
	____	_____	_____
	____	_____	_____

Other relative (s) with significant/similar problems to your complaint? _____
_____

Is the person completing this form the patient? □ Yes □ No
If no, state name and relationship to patient_____

PHYSICIAN REVIEW: **INITIALS** **DATE**

_____ _____
_____ _____
_____ _____
_____ _____

Pt. Name:_____Pt.#:_____DOB:_____