Name:____
Date:________________

PERSONAL HISTORY
Birthdate:____________ Birthplace:_____________
Marital Status M S D W
Occupations: ________________________________
____
Residence past 5 years: ______________________
Education through:________ Exercise: __________

HABITS
Alcohol Yes, how much:__________________
Never
Used to, how much: ______________
Tobacco Never
Stopped, When: ______________
How much before: __________
Yes, How much (now): ___________
Coffee No Yes, how much: ____________
Tea No Yes, how much: ____________
Sodas No Yes, how much:_____________
Type:______________________
Allergies: None
Drug allergies:____________________
Food allergies:___________________
Other allergies:__________________

MEDICATIONS:

Name	Dose

PAST HISTORY:

Operations	Approximate date

Hospitalizations (other than surgeries):

Reason	Where	When

FAMILY HISTORY

Condition	Yes	No	Who/What age
Heart Condition			
High Blood Pressure			
Lung Disease			
Strokes			
Tuberculosis			
Bleeding Problems			
Kidney Problems			
Diabetes			
Depression			
Alcoholism			
Mental illness			
Allergies			
Cancer			
Colon problems			
Other:			

IMMUNIZATION HISTORY
Tetanus Yes No When:__________________
Pneumonia Yes No When:__________________
Hepatitis B Yes No When:__________________

HAVE YOU EVER HAD:
Tuberculosis Yes No
Cancer Yes No
Transfusions Yes No
Back trouble Yes No
Bronchitis Yes No
Emphysema Yes No
Heart trouble Yes No
Stroke(s) Yes No
Hepatitis Yes No
IV Drugs Yes No
Kidney trouble Yes No
Glaucoma Yes No
Ulcers Yes No
Breast problems Yes No
Prostate trouble Yes No N/A
Bleeding trouble Yes No

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Have you experienced or have any of the following?

Persistent Fevers	Yes	No
Marked weight change	Yes	No
Skin rashes	Yes	No
Visual Problems	Yes	No
Wear glasses	Yes	No
Hearing loss	Yes	No
Nasal discharge	Yes	No
Persistent throat pain	Yes	No
Breast lumps	Yes	No
Breast discharge	Yes	No
Coughing	Yes	No
Morning Phlegm	Yes	No
Wheezing	Yes	No
Shortness of breath	Yes	No
With activities	Yes	No
At night	Yes	No
Ankle swelling	Yes	No
Palpitations	Yes	No
High blood pressure	Yes	No
Difficulty swallowing	Yes	No
Heartburn	Yes	No
Nausea or vomiting	Yes	No
Abdominal pain	Yes	No
Bloody or black stools	Yes	No
Bloating	Yes	No
Chronic constipation	Yes	No
Chronic diarrhea	Yes	No
Frequent urination-day	Yes	No
Frequent urination-night	Yes	No
Difficulty urinating	Yes	No
Leaking urine	Yes	No
Blood in urine	Yes	No
Lack of sex drive	Yes	No
Erection difficulty (men)	Yes	No
Thyroid problems	Yes	No
Diabetes	Yes	No
Low sugars	Yes	No
High cholesterol	Yes	No
Joint pains	Yes	No
Fainting	Yes	No
Depression	Yes	No
Anxiety	Yes	No
Memory loss	Yes	No
Excessive sleep	Yes	No
Difficulty sleeping	Yes	No

Have you ever used street drugs?
Yes No
What?________________________________
Do you still use street drugs?
Yes No
What/How much:________________________

Have you ever been told
you have an alcohol problem?
Yes No
Have you ever been concerned
about your alcohol use?
Yes No
Has anyone been concerned
about your alcohol use?
Yes No

Women only:
Are you still having periods? Yes No
If yes, are they regular? Yes No
If not regular, explain:___________________________
____
If you stopped, at what age?_____________________
Number of pregnancies:_________________________
Number of children:_____________________________
Weight of babies at birth (range):_________________
Have you ever had
an abnormal pap smear? Yes No
Last pap smear:_________________________________
Last mammogram:_______________________________

Who was your previous doctor?
Name, address & telephone (if available):
____
____
____

Patient Signature:______________________________
Date:____________

Physician Signature:____________________________
Date:____________ Jean-Claude Hage, M.D.