**NAME DATE**  \_\_\_\_\_\_\_\_\_\_\_\_\_

**DOB**

Any questions/ concerns you have today:

**PAST MEDICAL PROBLEMS**

**PAST SURGERIES**

**ALLERGIES AND REACTION**

**CURRENT MEDICATIONS / MED CHANGES**

**OTHER PROVIDERS YOU SEE**

**SCREENING** Year Last Performed (if appropriate)

Colonoscopy: Mammogram: Pap smear:

**IMMUNIZATIONS** Circle if done, add year if known

Flu Pneumonia Shingles Covid Tdap

**FAMILY HISTORY**

Father Alive/ Deceased Age: Medical History:

Mother Alive/ Deceased Age: Medical History:

*Siblings and any medical conditions:*

*Children:*

**SOCIAL HISTORY**

*MARITAL STATUS*Married Divorced Single Widowed

*EMPLOYMENT*Occupation: # Years:

Primary Language:

*Race (circle one)* Black/ African American White Asian Other

Pacific Islander/ Native Hawaiian American Indian/ Native Alaskan

*Ethnicity (circle one)* Hispanic Latino Non Hispanic/Latino N/A

*Gender orientation (circle one)* Male Female Transgender N/A

*Sexual Orientation (circle one)* Straight Gay/Lesbian Bisexual N/A

|  |  |  |
| --- | --- | --- |
| **Tobacco Use**  *Never*  *Former* # Years smoked: \_\_\_\_  Year quit: \_\_\_\_\_  *Current* # Cigarettes/day: \_\_\_\_  # Years smoked: \_\_\_\_\_ | **Alcohol Use**  Never  Rarely  Socially  Daily | **Recreational Drug Use**  None  Yes, type: \_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |