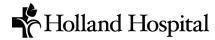


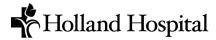
Adult Health History

lame:	Dat]	Date of Birth:
Current Medical Conditions				
Medications lease list all of the medications that you are cu	rrently taking. A	ttach additional	pages if needed.	
Name of medication			Dosage	Number of times dail
			_	
			_	
			_	
re you taking any of the following medication:	s? Please check \	es or No		
re you taking any of the following medication:	s? Please check \	es or No		
Medication	Yes			
Medication Aspirin	Yes			
Medication Aspirin Ibuprofen (Advil®) or naproxen (Aleve®) Vitamin D Calcium	Yes			
Medication Aspirin Ibuprofen (Advil®) or naproxen (Aleve®) Vitamin D	Yes			



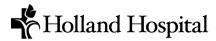
Allergies/Intolera	nce		
Please list any medica	ations allergies alor	ng with reac	ction (example: penicillin – rash). Attach additional sheets if necessary.
1.			
2.			
3.			
Do you have a latex a	allergy? □ Yes □	No	
Medical History			
Please list any medica	al conditions.		
1.			
2.			
3.			
4.			
5.			
6.			
Please check any other	er current/past med	dical conditi	ions you have not already listed above:
☐ Anemia	☐ Emphysem	a/COPD	☐ Liver disease
☐ Anxiety	☐ Glaucoma		☐ MRSA (staph) infection
☐ Arthritis	☐ Gout		☐ Osteoporosis/osteopenia
☐ Asthma	☐ Heart disea	se	☐ Sexually transmitted illness
☐ Blood clots	☐ High blood	pressure	☐ Skin cancer
Depression	☐ High choles	sterol	☐ Thyroid disease
□ Diabetes	☐ Kidney dise	ase	☐ Tuberculosis
Please indicate if you	have completed ar	ny of the fol	llowing procedures/treatments:
Procedure/ Treatme	ent	Yes [Date Completed
Flu vaccine			
Pneumonia vaccine	(Pneumovax®)		
Tetanus vaccine			
Shingles vaccine (Zo	ostavax)		
COVID-19 vaccine			
Colonoscopy			
Prostate cancer scre	eening (men)		
Mammography (wo	men)		
Bone density test (w	vomen)		

Pap test / pelvic exam (women)



Past Surgical History Please list your surgical history.

Type of Sur	rgery			Date of Su	rgery (Year)		Surgeon
	l/Gynecologica please indicate yo	al History our obstetrical and g	ynecological histor	y below.			
History of	Number		History of		Yes	No	
Pregnancie	S		HPV				
Miscarriage	es		Abnormal pap				
Abortions			Date of last mens	trual period			_
What is your	current form of b	oirth control? Please	check all that apply	y.			
□None	☐ Medication	☐ Tubal ligation	□ Vasectomy	□IUD	☐ Condom	ı	
Family His	tory						
	Health History			Living	If deceas	ed, list cau	se of death
Father							
Mother							
Siblings							
•					-		
•							
Children							



Social History

Occupation:
☐ Married ☐ Single ☐ Divorced ☐ Widowed
Do you exercise? ☐ Yes ☐ No
If yes, how many days per week?
Are you sexually active? ☐ Yes ☐ No
Have you ever smoked? ☐ Yes ☐ No
If yes, what? \Box cigarettes \Box pipe \Box cigars \Box e-cigs/vaping \Box chewing tobacco How many years?
Do you usually drink over 2 cups of caffeinated beverages per day? ☐ Yes ☐ No How many do you drink per day?
Do you regularly drink alcohol? 🔲 Yes 🔲 No
If yes, please check the answer(s) that best describe your consumption.
Liquor \Box 1 oz/day \Box 2 oz/day \Box 4 oz/day \Box 6+ oz/day
Beer □1 bottle/day □2 bottles/day □3+ bottles/day
Wine \Box 1 glass/day \Box 2 glasses/day \Box 3+ glasses/day