Date:________________Acct#:_______________ALLERGIES:___________________________

Patient Name:___________________________________Date of last Physical:_______________

LastTetanus________Last Hep B vaccine_________Last MMR vaccine________

Last Oral Polio vaccine________Last Flu Shot_________Last Hep A vaccine_________

Last Varicella vaccine________Have you had chicken pox?_________LastTB:________

Last Hep C Baseline:______Last HIV Screening_________

Has any blood relative ever had Tuberculosis(TB) Yes No If so, who:_________________
PERSONAL HISTORY:Have you ever had:

Measles	**Yes No**	**Headaches**	**Yes No**
Mumps	**Yes No**	**Back Pain**	**Yes No**
Polio/Meningitis	**Yes No**	**Leg Pain**	**Yes No**
Pneumonia	**Yes No**	**Arthritis**	**Yes No**
Pleurisy	**Yes No**	**Joint Pain**	**Yes No**
Cancer	**Yes No**	**Fatigue**	**Yes No**
Gonorrhea/Syphilis	**Yes No**	**Asthma**	**Yes No**
Sexually transmitted disease	**Yes No**	**Allergies**	**Yes No to what?_______**
Anemia	**Yes No**	**Heart Problems**	**Yes No**
AIDS	**Yes No**	**Hypertension**	**Yes No**
Colitis or other bowel disease	**Yes No**	**Weight loss/gain**	**Yes No**

Have you ever been treated for the above?: Yes No By Whom:________________________

Any other past medical diagnosis:_____________________Any past surgeries:______________

Performed by whom:______________________________Do you have a family physician, if so

who?:____

Do you smoke?: Yes No How many packs per day?:______Have you ever smoked?:_____

Do you drink?: Yes No How many drinks per day?:_______ Is there any other medical

conditions that we should know about?:____

Please list any family medical problems and from what family

member:____

WOMEN ONLY: Menstruation History:

Age of onset:________Cycle:________days from start to finish

Date of last period:________

Date of last pelvic/pap:___________Results: Neg Pos

Do you take birth control?: Yes No How long have you been taking them?:_______