

Name: _____
(Please Print)

PCP: _____
(Full Name of Primary Care Physician)

MEDICATIONS (list name & dosage)

DRUG ALLERGIES & REACTIONS

PREVIOUS SURGERIES

(list by year & type)

HEALTH MAINTENANCE (please circle)

Do you or did you smoke? Y N

Packs per day ____ Year quit ____

Do you use smokeless tobacco? Y N

Do you drink alcohol? Y N

Amount per week ____

Do you exercise regularly? Y N

Year of last physical exam ____

Do you have a pacemaker, neurostimulator,
stent or other metal device in your body? Y N

If yes, what and how long have you had it?

Do you or have you ever had metal fragments
in your eyes? Y N

Are you claustrophobic? Y N

Are you pregnant? Y N

Number of pregnancies? ____

Number of births? ____

Who do you live with? _____

Marital Status: (please circle)

Married, Single, Widow, Divorced

How many children do you have? ____

Occupation: _____

Date of Birth: _____

MEDICAL & FAMILY HISTORY

(check all that apply)

CONDITION	Yourself	Mother	Father	Sister	Brother
Alcoholism					
Asthma					
Cancer (type)					
Colitis/polyps					
Depression/ Anxiety					
Diabetes					
Glaucoma					
Heart Disease					
Hepatitis					
Hernia					
High Cholesterol					
HIV/AIDS					
Hypertension					
Seasonal Allergies					
Stroke					
Thyroid					
Ulcer					
Reflux					
Rheum Arth					
Other					

SPORTS/ ACTIVITIES/ EXERCISE HABITS

DIET Y N (if yes explain below)

HOBBIES/INTERESTS

Signature: _____ Date: _____