

INFORMATION FOR YOUR PHYSICIAN

Please answer the following questions prior to your first examination.
It will help your physician to know not only about your health but also about your family and relatives.

TODAY'S DATE

NAME		ADDRESS	
TELEPHONE NUMBER	DATE OF BIRTH	AGE	
EDUCATION (Highest level attained)		OCCUPATION ▶	HOW LONG

WHERE AND WHEN HAVE YOU LIVED OR TRAVELED OUTSIDE THE U.S. AND CANADA?

ALIVE ▶ DECEASED ▶	FATHER	Present health or cause of death	MOTHER	Present health or cause of death	SPOUSE	Present health or cause of death
	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
BROTHERS ▶	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH		
SISTERS ▶	NO. ALIVE	HEALTH	NO. DECEASED	CAUSE OF DEATH		
CHILDREN ▶	NO. ALIVE	AGES & HEALTH	NO. DECEASED	AGES & CAUSE OF DEATH		

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR **BLOOD RELATIVES** Diabetes Cancer Bleeding tendency Kidney disease
 Tuberculosis Heart disease Stroke High blood pressure Nervous illness Allergy Other

CHECK ANY ILLNESSES OR CONDITIONS YOU HAVE HAD Diabetes Glaucoma Heart trouble Syphilis Vein trouble
 Cancer Asthma Jaundice Gonorrhoea Bleeding tendencies Tuberculosis Pneumonia Kidney disease
 Rheumatic fever Nervous disorder Other

LIST OTHER ILLNESSES NOT REQUIRING OPERATION FOR WHICH YOU WERE HOSPITALIZED

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC.?

No Yes ▶ LIST:

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES?

NO Yes ▶ LIST:

DO YOU USE TOBACCO NOW?	IN THE PAST?	TYPE AND DAILY AMOUNT	HOW LONG?
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes		
DO YOU USE ALCOHOLIC BEVERAGES?	TYPE	WEEKLY AMOUNT	HOW LONG?
<input type="checkbox"/> No <input type="checkbox"/> Yes ▶			
DO YOU DRINK COFFEE?		WEEKLY AMOUNT	HOW LONG?
<input type="checkbox"/> No <input type="checkbox"/> Yes ▶			

CHECK THE DISEASES AGAINST WHICH YOU HAVE BEEN IMMUNIZED
 Smallpox Tetanus Typhoid Polio Influenza Other

PREVIOUS OPERATIONS (Dates, hospitals and name of surgeon)

DENTAL (List any problems you have now)

MEDICATIONS (Name or otherwise identify medicines now or recently used)

ONSET DATE OF LAST MENSTRUAL PERIOD	PERIODS ARE	NUMBER OF PREGNANCIES	NUMBER OF MISCARRIAGES
	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular		
HAVE YOU TAKEN CORTISONE-TYPE DRUGS?	ORAL CONTRACEPTIVES?	HAVE YOU RECEIVED A BLOOD TRANSFUSION?	
<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes	<input type="checkbox"/> No <input type="checkbox"/> Yes ▶ DATE:	

DRESSED WEIGHT HOW LONG HAVE YOU BEEN AT THIS WEIGHT?

WHAT IS YOUR MAIN MEDICAL PROBLEM AND HOW LONG HAVE YOU HAD IT?

WHAT IS YOUR MAIN SYMPTOM?

REVIEWED BY (Physician)

DATE