

Reason for last hospitalization: _____ Date: _____ Hospital: _____

Have you ever had any of the following medical conditions (Please *circle ALL that apply* & describe briefly below)

1-Diabetes	7-Hepatitis	14-Gained weight recently	21-Emotional problems
2-Stroke	8-Seizures	15-Lost weight recently	22-Nervousness
3-Cancer (list type below)	9-Convulsions	16-Heart disease	23-Anxiety
_____	10-Passing Out	17-High blood pressure	24-Depression
4-Lung Disease	11-Loss of consciousness	18-Kidney disease	25-Thyroid problems
5-Jaundice	12-Blood in urine	19-Stomach problems	26-Bladder changes
6-Liver Disease	13-Blood in bowel movement	20-Serious head injury	27-Bowel changes

List previous surgeries:

Family History:

Please use the following symbols for family members' relationship to the patient:
F=father, **M**=mother, **S**=sister, **B**=brother, **MGM**= maternal grandmother, **MGF**= maternal grandfather,
PGM=paternal grandmother, **PGF**=paternal grandfather, **A**=aunt, **U**=uncle

Relationship to the patient	Diseases that could be inherited from the family member
<i>Example: F, M, B</i>	<i>Diabetes</i>

Social History:

Do you?	Yes	No	Never	Quit	How much? # per day	What type? (circle if applicable)
Use Alcohol						beer, wine, hard liquor
Use Tobacco						cigarettes, cigars, pipe, snuff, leaf
Use Illicit Drugs						marijuana, cocaine, barbiturate, other _____
Consume Caffeine						coffee, tea, chocolate, soda
Have any risk for HIV						tattoo, piercing, multiple partners
Are you employed?			If employed, what is your occupation?			
Are you retired?						
What is your marital status: Single Engaged Married Separated Divorced Widowed Domestic Partnership						