Name________________________________

Past Medical History

Medical Illnesses	Self	Family- note which family member	Notes
Hepatitis A,B or C			
Diabetes			
Chronic Lung Disease/Asthma			
Cancer			
Thyroid Problem			
Blood Disorder/Anemia			
Heart Trouble/Murmur			
High Blood Pressure			
Kidney Disease			
Bowel Trouble/Ulcers			
Skin Disorders			
Arthritis			
Seizures			
Strokes			
Headaches			
STD'S (GC, Chlamydia, HPV, Herpes)			
Emotional/Depression/Anxiety			
Other			

Do you have a living will?	Yes	No	
Do you have a DNR?	Yes	No	

Surgery Year Procedure	Allergies Medications/Reactions	Immunizations
		Gardasil
		Hep B
		Hep A
		Tetanus
		Pneumonia
		Shingles
		H flu

Reviewed By _______________
Reviewed By_______________
Reviewed By_______________