

Patient Name: _____ **Date:** _____ **Doctor:** _____

Date of Birth: _____ Place of Birth: _____ Race/Nationality: _____
 Religion: _____ Education: _____ Occupation: _____

Marital Status/ Living Situation:

Married: _____ Single: _____ Divorced: _____ Widowed: _____ Domestic Partner: _____
 Live: Alone: _____ Family: _____ Assisted Living: _____ Other: _____
 Spouse/Partner's Name: _____ Occupation: _____
 Children (List Sex/Birth Year): _____

Habits (Circle Y=Yes, N=No):

Do you use Alcoholic Beverages? Y / N Type: _____ Amount/Frequency: _____ Former: _____
 Do you use Tobacco? Y / N Type: _____ Amount/Frequency: _____ Former: _____
 Do you use Recreational Drugs? Y / N Type: _____ Amount/Frequency: _____ Former: _____
 Do you drink Caffeinated Beverages? Y/N Type: _____ Amount/Frequency: _____ Former: _____
 Do you Exercise? Y / N Type: _____ Frequency: _____

Immunization Dates:

Tetanus _____	Transfusion: _____
Pneumonia _____	Travel History outside North America: _____
Hepatitis A _____	
Hepatitis B _____	Hazardous Exposure: Secondhand Smoke: _____
MMR _____	Asbestos: _____ Other: _____
Polio _____	Risk of HIV, Hepatitis, STDs: _____
Tuberculosis Skin _____	History of Domestic Violence: _____
Influenza _____	History of Childhood Abuse: _____
Other: _____	Wear Sunscreen: Yes / No Wear Seatbelt: Yes / No

Surgeries: Have you had the following surgeries (R=Right, L=Left, B=Both)?

Surgery:	Date:	Surgery:	Date:
Appendectomy _____	_____	Hernia: Location _____	_____
Back Surgery: _____	_____	Hysterectomy _____	_____
Neck _____	_____	Abdominal _____	Vaginal _____
Low Back _____	_____	Ovaries left in _____	Ovaries out: R / L / B _____
Breast Biopsy: R / L / B _____	_____	Tubal Ligation _____	_____
Breast Implant: R / L / B _____	_____	Joint/Bone Surgery _____	_____
Mastectomy: R / L / B _____	_____	Location _____	Side: R / L / B _____
Carotid Artery Surgery _____	_____	Prostate Surgery _____	_____
Cataracts: R / L / B _____	_____	Abdominal _____	Urethral _____
LASIK Eye Surgery: R / L / B _____	_____	Tonsillectomy _____	_____
Gallbladder: _____	_____	Vasectomy _____	_____
Laparoscopic _____	_____	Other: _____	_____
Open _____	_____		

Patient Name: _____

Hudson's Bay Medical Group

Past Medical History: Please circle if you Have Had or Have any of the following disorders/diagnoses.

Acne
 ADD (attention deficit disorder)
 ADHD (Attention deficit/
 Hyperactivity disorder)
 Alcoholism
 Alcoholism, in recovery
 Allergic Rhinitis
 Environmental Allergies
 Pollen / Cats / Dogs /
 Dust Mites / Other _____
 Alzheimer's Disease
 Anemia
 Anemia: Iron Deficiency
 Anticoagulation
 Anxiety
 Arthritis: Degenerative/Osteo
 What Joint? _____
 Arthritis: Rheumatoid
 Asthma
 Atrial Fibrillation
 Bee Sting Allergy
 Bipolar Disorder
 Cancer: Type: _____
 Colitis: Type: _____
 Coronary Artery Heart Disease
 Carpal Tunnel Syndrome
 Congestive Heart Failure
 Colon Polyps
 Constipation
 COPD (Chronic Obstructive Lung Disease)
 Depression
 Depression/ Anxiety

Dermatitis
 Diabetes, Type 1
 Diabetes, Type 2
 Disc Disease:
 Cervical
 Lumbar
 Diverticulosis
 Dizziness
 Edema
 Emphysema
 Endometriosis
 Erectile Dysfunction
 GERD/Heartburn
 Gout
 Headache
 High Blood Pressure
 High Cholesterol/Lipids
 Hyperglycemia/Sugar
 Hypogonadism
 Incontinence: Stress/ Urge
 Irritable Bowel Syndrome:
 Symptom: Diarrhea/
 Constipation/ Pain
 Insomnia
 Interstitial Cystitis
 Kidney Stones
 Kidney Disease
 Liver Disease
 Low Back Pain
 Menopause
 Migraine
 Neck Pain

Neuropathy
 Osteopenia
 Osteoporosis
 Peripheral Artery Disease
 Polycystic Ovary Syndrome
 Prostate Enlargement
 Psoriasis
 Pulmonary Embolism
 Restless Leg Syndrome
 Rosacea
 Sciatica
 Seborrhea/ Seborrheic/
 Dermatitis
 Seizure Disorder
 Shingles
 Sleep Apnea
 Stroke
 Thyroid Disorder:
 Overactive/ Underactive/
 Nodule
 Transient Ischemic Attack
 Tremor
 Tuberculosis
 Ulcer: Where? _____
 Urinary Tract Infections
 Vein Clot
 Vertigo
 OTHER DIAGNOSES:

Family Medical History: **** Has anyone in your family had? For Aunts/Uncle/Grandparents, Please indicate if they are Mother or Father's side, and how old when they got the disease. ****

Disease:	Family Member:
Cancer:	_____
Breast	_____
Colon	_____
Ovary	_____
Prostate	_____
Other	_____
Colon Polyps	_____
Diabetes	_____
High Blood Pressure	_____
High Cholesterol	_____
Stroke	_____

Disease:	Family Member:
Coronary Artery Disease/ Heart Attack:	_____
Kidney Disease	_____
Depression	_____
Anxiety	_____
Alcoholism	_____
Thyroid Disease:	_____
Type:	_____
Alzheimer's Disease	_____
Migraines	_____
Other:	_____

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Procedures: Have you had: CT's, US's, MRI's, EKG's etc? Please give details such as L or R, and area of body (ex. R leg CT).

Procedures:	Date:	Result:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Other physicians you are seeing:	Type:
_____	_____
_____	_____
_____	_____

Medication Allergies:	Reaction:
_____	_____
_____	_____
_____	_____
_____	_____

Medications: Please list all prescription and nonprescription medications.

Supplements/OTC:

Medication:	Dose:	Dose per day:	Who Prescribed:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____