

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	_____
Open	_____	Laparoscopic	_____
Other: _____	_____		_____

Patient Name: \_\_\_\_\_

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

- |   |  |                                      |
|---|--|--------------------------------------|
| Acne  | Dermatitis                               | Neuropathy                           |
| ADD (attention deficit disorder)                    | Diabetes, Type 1                         | Osteopenia                           |
| ADHD (Attention deficit/<br>Hyperactivity disorder) | Diabetes, Type 2                         | Osteoporosis                         |
| Alcoholism  | Disc Disease:                            | Peripheral Artery Disease            |
| Alcoholism, in recovery                             | Cervical                                 | Polycystic Ovary Syndrome            |
| Allergic Rhinitis                                   | Lumbar                                   | Prostate Enlargement                 |
| Environmental Allergies                             | Diverticulosis                           | Psoriasis                            |
| Pollen / Cats / Dogs /                              | Dizziness                                | Pulmonary Embolism                   |
| Dust Mites / Other _____                            | Edema                                    | Restless Leg Syndrome                |
| Alzheimer's Disease                                 | Emphysema                                | Rosacea                              |
| Anemia  | Endometriosis                            | Sciatica                             |
| Anemia: Iron Deficiency                             | Erectile Dysfunction                     | Seborrhea/ Seborrheic/<br>Dermatitis |
| Anticoagulation                                     | GERD/Heartburn                           | Seizure Disorder                     |
| Anxiety   | Gout                                     | Shingles                             |
| Arthritis: Degenerative/Osteo                       | Headache                                 | Sleep Apnea                          |
| What Joint? _____                                   | High Blood Pressure                      | Stroke                               |
| Arthritis: Rheumatoid                               | High Cholesterol/Lipids                  | Thyroid Disorder:                    |
| Asthma  | Hyperglycemia/Sugar                      | Overactive/ Underactive/<br>Nodule   |
| Atrial Fibrillation                                 | Hypogonadism                             | Transient Ischemic Attack            |
| Bee Sting Allergy                                   | Incontinence: Stress/ Urge               | Tremor                               |
| Bipolar Disorder                                    | Irritable Bowel Syndrome:                | Tuberculosis                         |
| Cancer: Type: _____                                 | Symptom: Diarrhea/<br>Constipation/ Pain | Ulcer: Where? _____                  |
| Colitis: Type: _____                                | Insomnia                                 | Urinary Tract Infections             |
| Coronary Artery Heart Disease                       | Interstitial Cystitis                    | Vein Clot                            |
| Carpal Tunnel Syndrome                              | Kidney Stones                            | Vertigo                              |
| Congestive Heart Failure                            | Kidney Disease                           | OTHER DIAGNOSES:                     |
| Colon Polyps  | Liver Disease                            | _____                                |
| Constipation  | Low Back Pain                            | _____                                |
| COPD (Chronic Obstructive Lung Disease)             | Menopause                                | _____                                |
| Depression  | Migraine                                 | _____                                |
| Depression/ Anxiety                                 | Neck Pain                                | _____                                |

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:	Disease:	Family Member:
Cancer:	_____	Coronary Artery Disease/ Heart Attack:	_____
Breast	_____	Kidney Disease	_____
Colon	_____	Depression	_____
Ovary	_____	Anxiety	_____
Prostate	_____	Alcoholism	_____
Other	_____	Thyroid Disease:	_____
Colon Polyps	_____	Type:	_____
Diabetes	_____	Alzheimer's Disease	_____
High Blood Pressure	_____	Migraines	_____
High Cholesterol	_____	Other: _____	_____
Stroke	_____		

Patient Name: \_\_\_\_\_

Hudson's Bay Medical Group

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:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____