

Aurora Internal Medicine Clinic, PC

Name: _____ DOB: _____ Date: _____

Reason for today's visit: _____

Allergies: _____

Medications & doses: _____

Vitamins/Herbal products? _____

Previous Surgeries: _____

Other Health Problems: _____

Other Doctors treating you: _____

Family History:

	Father	Mother	Grandparents	Siblings	Children
High Blood Pressure					
Heart Attack					
Stroke					
High Cholesterol					
Blood Clots					
Cancer type?					
Diabetes					
Asthma					
Emphysema					
Kidney Stones					
Ulcers					
Depression					
Other (please list)					

Immunizations dates:
 Last tetanus: _____
 Last Flu shot: _____
 Last Pneumovax: _____
 Prevnar-13: _____
 Hep A: _____
 Hep B: _____
 Shingles _____

Last physical: _____
 Last mammogram: _____
 Last PAP: _____
 Last colonoscopy: _____
 Last Bone density _____

Occupation: _____

Are you under any stress at home/work? _____ Describe? _____

Marital status: married single widowed separated divorced x _____ # of children _____

Exercise regimen: _____

Do you use tobacco? _____ (cigars chewing tobacco cigarettes) _____ packs/day _____ # of yrs

Have you ever smoked/chewed? _____ Packs/cans/day _____ # of years smoked/chewed _____

Do you drink alcohol? _____ Type? _____ How much? _____ /day or week

Cups of coffee/day _____ Sodas/day _____ Tea/day _____ Pets _____

Are you pregnant? _____ Are you planning a pregnancy? _____ Any Tattoos? _____

Have you ever had any blood transfusions? _____ Any body piercing besides ears? _____

Illicit street drugs/IV drugs/nasal drugs? _____

Is there anything that hasn't been asked that you would like to tell the doctor?
