

Adult Immunizations Review – Please list the Date of your Last Immunizations (write N/A if not applicable):

Flu: _____ Pneumonia: _____ Shingles: _____ Tdap (Tetanus, Diphtheria & Pertussis): _____

ALLERGIES: Are you allergic to any of the following? (*Circle all that apply*) **None** Aspirin Penicillin Codeine
 Metal Latex Local Anesthetics Other: _____

If yes, explain the reaction: _____ Anaphylaxis: **YES / NO**

SOCIAL HISTORY:

Family / Household member (Everyone who lives in your household):

Name	Birth Year	Relationship	

Did you EVER or do you smoke cigarettes or use other tobacco products? (*please circle*) **YES NO**

Type: _____

Age started _____ Age quit _____ How many packs per day? _____

Do you use any marijuana, cocaine, or non-prescribed narcotics? (*please circle*) **YES NO**

If so, please describe: _____

How many cups of caffeinated coffee, tea, or carbonated beverage do you drink daily? _____

How many beers, mixed drinks, or glasses of wine do you have weekly? _____

FAMILY HISTORY:

Please check if Mother, Father, Brother/Sister or Grandparents have had any of the following: For Grandparents, please indicate M for Mother’s side of family or P for Father’s side of family.

	Mother	Father	Brother/Sister	Grandmother	Grandfather	Age at onset
Alcoholism						
Allergies						
Diabetes						
Tuberculosis						
Heart Disease						
Stroke						
High Blood Pressure						
Depression / Anxiety / Bipolar						
Suicide						
Cancer						
High Cholesterol						
Thyroid issues						
Major medical problems						

WOMEN ONLY	
Dates of last two Periods	_____
Current method of contraception	_____
Number of previous: Pregnancies _____ Miscarriages _____ Live Births _____ Terminations _____	
AGE at Menopause	_____
Date of Last: PAP Test: _____ Mammogram: _____ Dexascan: _____ Colonoscopy (50+): _____	

MEN ONLY	
Do you perform monthly testicular self-exams (TSE)?	
	<input type="checkbox"/> Yes <input type="checkbox"/> No
Date of Last PSA Test:	_____
Date of Last Colonoscopy (50+)	_____