IF YES, CHECK THE BOX for YOURSELF or FAMILY MEMBER who has or had any problem listed:

Medical Condition	Me Past	Me Now	My Mom	My Dad	My Sister	My Brother	My Kids	My Grandparent
ADHD								
Alcoholism								
Allergies								
Anemia								
Arthritis								
Anxiety								
Asthma								
Birth Defects								
Bipolar Disorder								
Cancer/Type								
Constipation								
Diabetes								
Depression								
Drug Use								
Lung Issues								
Gout								
Hearing Loss								
Heart Attack								
HIV/AIDS								
High Cholesterol								
Hypertension								
Irritable Bowel								
Insomnia								
Kidney Problems								
Liver Disease								
Migraines								
Obesity								
Pain Medicines								
Sleep Apnea (CPAP)								
STD (Sexually Transmit)								
Stroke								
Suicide								
Thyroid Problem								
Vision Loss								

MEN ONLY	YES	NO	SOMETIMES
Testicular Pain			
Urinary Problems			
Erectile Dysfunction			
Sexually Active			

ALL PATIENTS write down anything else you'd like to discuss

WOMEN ONLY	
Date of Last Pap	
Date of Last MAMMO	
# of Pregnancies _____	
# of Abortions _____	
# of Miscarriages _____	
Last Period ___ _____ Age Period Started _____ Still Have it? Yes or No	

	YES	NO	SOMETIMES
Sexually Active			
Vaginal Discharge			
Vaginal Burning			
Abnormal Bleeding			
Birth Control			Type:

NEED PAP: YES or NO

NEED MAMMOGRAM: YES or NO