

Patient Name: _____
WMG Account Number _____

Patient Medical History

Home Phone: _____ Work Phone: _____ Cell Phone: _____
Date of Birth: _____ Age: _____ Gender: Male Female
Birthplace: _____ Religion: _____
Marital Status: Single Married Divorced Widowed
Ethnicity/Race: Hispanic Asian Caucasian African American American Indian Other
Language: English Spanish American Sign Language Other _____
Referring Doctor: _____ Address: _____ Phone: _____
Family Doctor: _____ Address: _____ Phone: _____
Gynecologist: _____ Address: _____ Phone: _____
Orthopedic Surgeon: _____ Address: _____ Phone: _____

PERSONAL AND SOCIAL HISTORY

Do you live alone? Yes No If no, who do you live with: _____
Are you presently employed? Yes No If no, are you: Retired Disabled
Present Occupation: _____ Full-Time Part-Time
Past Occupation: _____ Unable to work since: _____
Education: _____
Do you regularly consume alcohol? Never In the Past Currently
Average number of drinks per week (now or in the past)? 7 or less (O) 8-14 (M) 15 + (H)
How would you describe your cigarette smoking? Never In the Past Currently
How many packs per day do you (or did you) smoke? _____ For how many years: _____
Do you use other tobacco products? Specify: _____ Never In the Past Currently
Does anybody smoke in the house in which you live? Never In the Past Currently
How many caffeinated beverages do you consume per day? 0 1-2 3-5 More than 5 Occasional
IV drug use or other recreational drug use? Never In the Past Currently
Have you engaged in high risk behavior for sexually transmitted diseases (anal sex, multiple sex partners, same sex)?
Never In the Past Currently
Where have you lived (geographically)? _____
Have you recently traveled outside of the US? Yes No When/ Where? _____
Have you ever had a Blood Transfusion? Yes No
Do you have any Body Piercings/ Tattoos? Yes No When obtained? _____
How is your appetite? Good Stable Poor
Have you been gaining/losing weight? Yes No How much? _____
Was the weight change intentional? Yes No
How much weight change have you experienced? _____ Over how many months? _____
Are you on a special diet? Yes No What kind? _____
Exercise Habits: _____
Sports or Hobbies: _____
Military Service: _____

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PATIENT MEDICAL HISTORY CONTINUED

SURGERIES (Please mark all surgeries you have had)

	Month/Year		Month/Year
Appendectomy (Appendix) <input type="checkbox"/>	_____	Transplant (Specify: _____) <input type="checkbox"/>	_____
Cholecystectomy (Gallbladder) <input type="checkbox"/>	_____	Heart (Specify: _____) <input type="checkbox"/>	_____
Tonsillectomy <input type="checkbox"/>	_____	TURP <input type="checkbox"/>	_____
Adenoidectomy <input type="checkbox"/>	_____	Prostatectomy <input type="checkbox"/>	_____
Eyes (Specify: _____) <input type="checkbox"/>	_____	Knee Arthroscopy <input type="checkbox"/>	_____
Ears (Specify: _____) <input type="checkbox"/>	_____	Knee Replacement <input type="checkbox"/>	_____
Nose (Specify: _____) <input type="checkbox"/>	_____	Hip Replacement <input type="checkbox"/>	_____
Throat (Specify: _____) <input type="checkbox"/>	_____	Other Joint Replacement <input type="checkbox"/>	_____
Brain Surgery <input type="checkbox"/>	_____	Shoulder Surgery <input type="checkbox"/>	_____
Breast (Specify: _____) <input type="checkbox"/>	_____	Wrist Surgery <input type="checkbox"/>	_____
Colon/ Intestinal <input type="checkbox"/>	_____	Back Surgery (Specify: _____) <input type="checkbox"/>	_____
Hernia Surgery <input type="checkbox"/>	_____	Joint Fusion <input type="checkbox"/>	_____
Weight loss (Bypass/ Banding) <input type="checkbox"/>	_____	Spinal Fusion <input type="checkbox"/>	_____
Heart Valve Replacement <input type="checkbox"/>	_____	Coronary Artery Bypass Graft <input type="checkbox"/>	_____
Hysterectomy (Indicate type of Hysterectomy: Total or Partial / Abdominal or Vaginal) <input type="checkbox"/>	_____	Other _____ <input type="checkbox"/>	_____
Other _____ <input type="checkbox"/>	_____	Other _____ <input type="checkbox"/>	_____
Other _____ <input type="checkbox"/>	_____	Other _____ <input type="checkbox"/>	_____
Other _____ <input type="checkbox"/>	_____	Other _____ <input type="checkbox"/>	_____

OTHER CONDITIONS

	Month/Year		Month/Year
Stroke <input type="checkbox"/>	_____	Tuberculosis (TB) <input type="checkbox"/>	_____
High Blood Pressure <input type="checkbox"/>	_____	Multiple Sclerosis <input type="checkbox"/>	_____
Heart Attack <input type="checkbox"/>	_____	Arthritis <input type="checkbox"/>	_____
Heart Disease <input type="checkbox"/>	_____	Rheumatoid Arthritis <input type="checkbox"/>	_____
High Cholesterol <input type="checkbox"/>	_____	Osteoarthritis <input type="checkbox"/>	_____
Congestive Heart Failure <input type="checkbox"/>	_____	Psoriatic Arthritis <input type="checkbox"/>	_____
Abnormal Heartbeat/ Palpitations <input type="checkbox"/>	_____	Osteoporosis <input type="checkbox"/>	_____
Blood Disease/Bleeding Disorder <input type="checkbox"/>	_____	Gout <input type="checkbox"/>	_____
Anemia <input type="checkbox"/>	_____	Fibromyalgia <input type="checkbox"/>	_____
Blood Clots <input type="checkbox"/>	_____	Lupus <input type="checkbox"/>	_____
Hardening of the Arteries <input type="checkbox"/>	_____	Kidney Disease <input type="checkbox"/>	_____
Treatment with Blood Thinner <input type="checkbox"/>	_____	Seizure Disorder (Epilepsy) <input type="checkbox"/>	_____
Diabetes (Circle: Type I/Type II) <input type="checkbox"/>	_____	Thyroid Disease <input type="checkbox"/>	_____
Asthma <input type="checkbox"/>	_____	Stomach Ulcer <input type="checkbox"/>	_____
Emphysema or COPD <input type="checkbox"/>	_____	Cancer (Specify: _____) <input type="checkbox"/>	_____
Hepatitis (Circle: Type B/Type C) <input type="checkbox"/>	_____	Depression <input type="checkbox"/>	_____
Exposure to/Positive for HIV <input type="checkbox"/>	_____	Antibiotic Treatment (past 2 mon.) <input type="checkbox"/>	_____
Other _____ <input type="checkbox"/>	_____	Other _____ <input type="checkbox"/>	_____
Other _____ <input type="checkbox"/>	_____	Other _____ <input type="checkbox"/>	_____
Other _____ <input type="checkbox"/>	_____	Other _____ <input type="checkbox"/>	_____

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FAMILY HISTORY

	Age	Health			Age at Death	Cause of Death
Father		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Mother		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Brothers:		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Sisters:		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Maternal Grandfather		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Maternal Grandmother		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Paternal Grandfather		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Paternal Grandmother		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Spouse		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Sons:		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
Daughters:		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		
		Good <input type="checkbox"/>	Stable <input type="checkbox"/>	Poor <input type="checkbox"/>		

Please list all family members effected by the following:

Family History Unknown

Adopted

M = Mother	MGM = Maternal Grandmother	MGF = Maternal Grandfather	F = Father
PGM = Paternal Grandmother	PGF = Paternal Grandfather	B = Brother	S = Sister
O = Other immediate family			
Alcohol Abuse _____			Hepatitis B _____
Bleeding Disorder _____			Hepatitis C _____
Blood Clots _____			Hypertension _____
Cancer, Breast _____		Irritable Bowel Syndrome _____	Kidney Disease _____
Cancer, Ovarian _____			Mental Illness _____
Cancer, Lung _____			Osteoporosis _____
Cancer, Prostate _____			Osteoarthritis _____
Cancer, Stomach _____		Other Arthritis (Please specify) _____	
Cancer, Uterine _____		Pancreatitis _____	
Cancer, Colon _____		Rheumatoid Arthritis _____	
Cancer, Other _____		Seizure Disorders _____	
Crohn's Disease _____		Sickle Cell _____	
Diabetes _____		Stroke _____	
Liver Disease _____		Thyroid _____	
Gallstones _____		Tuberculosis (TB) _____	
Gout _____		Ulcer Disease _____	
Heart Attack _____		Ulcerative Colitis _____	
Heart Disease _____			
Other _____		Other _____	
Other _____		Other _____	