

Quaker Medical Associates

Name: _____ Date of birth: _____ Sex: _____ Today's date: _____

Emergency Contact: _____ Relationship: _____

Phone # _____ Cell # _____ Work # _____

Spouse name: _____ Phone # _____ Cell # _____

Preventative Health: Please indicate Date of most recent test/screening

Eye exam _____	Mammogram _____
Bone Density _____	PAP _____
Colonoscopy _____	Physical Exam _____
Dental Exam _____	PSA _____
Tetanus vaccine _____	PPD (TB Test) _____
	Prostate Exam _____

Do you have a Health Care Proxy or Living Will? Yes / No

****Please provide a copy for your medical record**

If no, have end of life forms been discussed with you? Yes / No

Are you an organ donor? Yes / No

Have you been exposed to HIV or Hepatitis? Yes / No

Childhood Illnesses: (Please circle all that apply)

ADHD/ADD	Depression	Polio
Acne	Diphtheria	Scarlet fever
Respiratory issues or illness	Ear infections	Strep Throat
Heart issues or illness	Measles / Mumps	Sinus infections (recurrent)
Cerebral Palsy	Meningitis	Rubella
Chicken Pox	Mono	Rheumatic Fever

Other: _____

Family History

	Age	Medical History/Health Status	If deceased: Age and cause of death
Father	_____	_____	_____
Mother	_____	_____	_____
Paternal Grandfather	_____	_____	_____
Paternal Grandmother	_____	_____	_____
Maternal Grandfather	_____	_____	_____
Maternal Grandmother	_____	_____	_____
Siblings (circle sex)			
M F	_____	_____	_____
M F	_____	_____	_____
M F	_____	_____	_____
M F	_____	_____	_____
Children			
M F	_____	_____	_____
M F	_____	_____	_____
M F	_____	_____	_____
M F	_____	_____	_____
M F	_____	_____	_____

Do you have a family history of early heart disease in father or brother before age 55 or in mother or sister before age 65? Yes / No

Name: _____

Date of Birth: _____

Current/ Past Health History (Please circle all that apply)

Aneurysm	Respiratory Issues (type): _____	Osteopenia/Osteoporosis
ADHD	Ear Infections	Pelvic Uterine Disease
AIDS/HIV	Enlarged Prostate	Palpitations
Acne	Epilepsy/ Seizure Disorder	Pancreatitis
Allergies	Erectile Dysfunction	Parkinson's Disease
Alzheimer's	Esophagitis	Peripheral Vascular Disease
Anemia	Gall Bladder issues	Phlebitis / Blood Clot
Arteriosclerosis	GERD Gastric Reflux	Sexually transmitted disease
Arthritis (type): _____	Glaucoma	Seizures
Atrial Fib	Gout	Sickle Cell Anemia
Bladder Infections	Hearing issues	Sinus Issues
Blood disorder (type) _____	Headaches/Migraines	Suicide attempt
Blood Transfusion: Yes / No	Hiatal Hernia	Testosterone Deficiency
Cancer (type): _____	Hodgkin's Disease	Thyroid Disease
Carotid Artery Stenosis	High Cholesterol	Tuberculosis
Cataracts	High Blood pressure	Tumors
CVA/Stroke/ TIA	Hyper / Hypothyroidism	Ulcers
Cirrhosis	Incontinence	Varicose Veins
Colitis	Infertility	Venous Insufficiency
Colon Polyps	Kidney Issues (type): _____	Vertigo
Cardiac Issues (type): _____	Liver Disease	Healthy: no issues
Coronary Heart Disease	Lupus	Other: _____
Crohn's Disease	Menieres Disease	_____
Depression/Anxiety	Mental Illness	_____
Diabetes (type): _____	Multiple Sclerosis	_____
Diverticulitis/ Diverticulosis	Obesity	Number of pregnancies _____
		Miscarriages/abortions _____

History of drug use: (circle) Never Former Current Drugs: _____

Hospitalizations/ Injuries/Surgeries (Please list all with year if possible): _____

<u>Allergies</u>	<u>Reaction</u>
(food, animals, drugs, etc)	(hives, rash, wheezing, upset stomach, swelling, etc)

Marital Status: _____

Occupation: _____

Smoking history

Current Yes / No Packs per day _____

Past history, but quit Yes / No

Alcohol use: Quantity _____ Frequency _____

Exercise (circle): Sedentary < 3 times per week

Moderate, 3 times Active, 6 times/week

Vigorous, 6 times/week for 60 minutes

Special Diet: _____

Caffeine use: cups per day _____

Do you live alone? Yes / No

Pets in home? (type) _____

Current medications including vitamins, herbals and over-the-counter medications:

Name	Dose	Frequency	Name	Dose	Frequency

Signature: _____