Name: _____ Date of Birth: _____

1. Date of last physical: _____ Where_____

2. Any Significant Illnesses/Accidents (Indicate year also):

_____
_____
_____

3. Surgeries/Hospitalizations: (Indicate year):

_____Appendectomy or Aortic Surgery
_____Breast Biopsy
_____C-Section
_____Cardiac-Angioplasty-Valves
_____Cataract or Intraocular Lens
_____Colon or Rectal Surgery
_____D and C
_____Gallbladder Removal
_____Gastric Bypass
_____Hysterectomy
_____Joint Replacements
_____Kidney-Bladder- Ureter
_____Rhinoplasty or Plastic Surgery
_____Thyroidectomy
_____Tonsillectomy
_____Tubal Ligation
_____Tubes in Ears or Mastoids
_____Vasectomy

4. Please add date of test to the following:

_____Chest x-ray
_____ Pneumonia Shot
_____TB Time or PPD
_____Tetanus or Diptheria
_____Urinalysis
_____Vision exam
_____Herpes Zoster Shot
_____Cholesterol Screening
_____EKG - Echo-Stress
_____Hemoccult
_____Hepatitis A/B Shot
_____Pap Smear
_____H1N1 Shot
_____Influenza Shot
_____Meningitis Vaccine
_____Mammogram

Other Shots with dates: _____

5. List of Medications:

Name Strength How often taken?

_____
_____
_____
_____
_____

Allergies: _____

6. Non-prescription medicines/vitamins/herbals, etc.

_____
_____
_____

7. Other dates/incidences that are important to know:

_____
_____