HONORHEALTH
Medical Group

NAME: _____ **DATE OF BIRTH:** _____

REASON FOR TODAY'S VISIT: _____

Please list your CURRENT MEDICATIONS/VITAMINS/SUPPLEMENTS	
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

Please list your ALLERGIES TO MEDICATIONS			
❑ No Known Allergies	❑ Penicillin Reaction: _____	❑ Sulfa Reaction: _____	❑ Codeine Reaction: _____
	❑ Latex Reaction: _____	❑ Iodine Reaction: _____	❑ Adhesive Reaction: _____
Other allergies with reactions:			

Past Medical History

❑ Yes ❑ No	Acid Reflux of Stomach (GERD)	❑ Yes ❑ No	Heart Disease
❑ Yes ❑ No	Acute Myocardial Infarction (Heart Attack)	❑ Yes ❑ No	High Cholesterol or High Lipids
❑ Yes ❑ No	Anemia	❑ Yes ❑ No	Hypertension (High Blood Pressure)
❑ Yes ❑ No	Asthma	❑ Yes ❑ No	Hypothyroidism (Low Thyroid)
❑ Yes ❑ No	Atrial Fibrillation	❑ Yes ❑ No	Kidney Disease
❑ Yes ❑ No	Autoimmune Disease Type: _____	❑ Yes ❑ No	Obesity
❑ Yes ❑ No	Blood Dyscrasias (Blood Clotting Disorder) Type: _____	❑ Yes ❑ No	Osteoporosis
❑ Yes ❑ No	Cancer, Breast	❑ Yes ❑ No	Parkinson's Disease
❑ Yes ❑ No	Cancer, Other Type: _____	❑ Yes ❑ No	Sleep Apnea
❑ Yes ❑ No	COPD	❑ Yes ❑ No	Seizures
❑ Yes ❑ No	Diabetes	❑ Yes ❑ No	Transient ischemic attack (stroke)
❑ Yes ❑ No	Emphysema	❑ Yes ❑ No	Other Medical Problem(s):

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Surgical History

❑ Yes ❑ No	Appendectomy (Appendix Removed)		Date: _____
❑ Yes ❑ No	Bladder Surgery		Date: _____
❑ Yes ❑ No	Brain Surgery		Date: _____
❑ Yes ❑ No	Breast Biopsy	❑ Left side Date: _____	❑ Right side Date: _____
❑ Yes ❑ No	Breast Lumpectomy	❑ Left side Date: _____	❑ Right side Date: _____
❑ Yes ❑ No	Breast Mastectomy	❑ Left side Date: _____	❑ Right side Date: _____
❑ Yes ❑ No	Breast Augmentation		Date: _____
❑ Yes ❑ No	Breast Reduction		Date: _____
❑ Yes ❑ No	Carotid Endarterectomy		Date: _____
❑ Yes ❑ No	Cesarean Section		Date: _____
❑ Yes ❑ No	Cholecystectomy (Gallbladder Removal)		Date: _____
❑ Yes ❑ No	Cataract removal		Date: _____
❑ Yes ❑ No	Dental surgery		Date: _____
❑ Yes ❑ No	Heart surgery		Date: _____
❑ Yes ❑ No	Hysterectomy with both ovaries left in		Date: _____
❑ Yes ❑ No	Hysterectomy with both ovaries removed		Date: _____
❑ Yes ❑ No	Hysterectomy with one ovary removed Side of removal: ❑Left ❑Right		Date: _____
❑ Yes ❑ No	Nephrectomy (Kidney Removal)		Date: _____
❑ Yes ❑ No	Tonsillectomy		Date: _____
❑ Yes ❑ No	Total Joint Replacement Type: _____ Side of replacement: ❑Left ❑Right		Date: _____
❑ Yes ❑ No	Transplant (Kidney, Heart, Lung, Liver, etc.) Side of transplant (if applicable): ❑Left ❑Right		Date: _____
❑ Yes ❑ No	Other Surgery Type: _____		Date: _____
❑ Yes ❑ No	Other Surgery Type: _____		Date: _____

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Family History of Cancer

Family Member	Affected	Mother's Side / Father's Side	Type of cancer	Age of diagnosis	Current age	If deceased, age
Mother	❑ Yes ❑ No	N/A				
Father	❑ Yes ❑ No	N/A				
Daughter	❑ Yes ❑ No	N/A				
Son	❑ Yes ❑ No	N/A				
Sister	❑ Yes ❑ No					
Brother	❑ Yes ❑ No					
Grandmother	❑ Yes ❑ No	❑ Mother's Side ❑ Father's Side				
Grandfather	❑ Yes ❑ No	❑ Mother's Side ❑ Father's Side				
Aunt	❑ Yes ❑ No	❑ Mother's Side ❑ Father's Side				
Uncle	❑ Yes ❑ No	❑ Mother's Side ❑ Father's Side				
Cousin	❑ Yes ❑ No	❑ Mother's Side ❑ Father's Side				
Other:	❑ Yes ❑ No					
Are you Ashkenazi Jewish? (We ask due to this subgroup having high incidence of breast cancer)					❑ YES	❑ NO
GENETIC TESTING: Have you previously had Genetic Testing?					❑ YES	❑ NO

OB/GYN History

How old were you when you had your first menstrual cycle?			
How old were you when you experienced menopause?			
How many pregnancies have you had?			
Number of births?			
How old were you when you had your first child?			
Have you taken oral contraceptives?	❑ Yes ❑ No	If yes, how long? _____	Currently taking? ❑ Yes ❑ No
Have you taken fertility treatments?	❑ Yes ❑ No	If yes, how long? _____	Currently taking? ❑ Yes ❑ No
Have you taken hormone replacement therapy medication?	❑ Yes ❑ No	If yes, how long? _____	Currently taking? ❑ Yes ❑ No

Social History

Do you consume alcohol?	❑ Yes ❑ No	If Yes, how many ounces per day?
Do you consume caffeine daily?	❑ Yes ❑ No	If Yes, how much per day?
Do you smoke? Marijuana use?	❑ Yes ❑ No ❑ Yes ❑ No	If Yes, how many packs per day? If Yes, how often?
Are you a former smoker?	❑ Yes ❑ No	If yes, how long did you smoke? If yes, when did you quit? Date: _____