UCLA Health System

Date __________
Name_________________________________
Address_______________________________
Occupation____________________________
Previous Primary Physician______________

List the Following:

Prior Hospitalizations and surgeries
(include dates and diagnosis)

____
____
____
____
____
____

Past serious illness/current medical problems/
psychological issues for which you are under treatment

____
____
____
____
____
____

Current Medications and dosages:

____
____
____
____
____
____

Current "as needed" medications and dosages:

____
____

Medication Allergies (describe reaction):

____
____

List your previous Primary Physician and any other
physicians who follow you and your condition(s):

____
____
____

Please list the dates and results of any of the following tests/vaccines you may have had:

Test/Vaccine	Date and results
Physical Exam	
Colonoscopy	
Cardiac Stress Test	
Mammogram	
Pap Smear	
Bone Density	
Pneumonia Vaccine	
Diptheria Tetanus shot	
Chickenpox/vaccine	
Hepatitis B shot	
HPV vaccine	
Shingles vaccine	
Travel vaccines	

Current Marital Status:
- ☐ Single
- ☐ Married
- ☐ Separated
- ☐ Divorced
- ☐ Domestic Partnered

Number of Children____
(women only)
# of pregnancies____
# of live births_____
# of miscarriages____
# of abortions_____

Do you have regular Periods? ☐ Yes ☐ No

Date of last regular period: ___/___/___

Preferred Sexual Partner:
☐ Men ☐ Both
☐ Women ☐ Not sexually active
Number of sexual partners in past year:____
Form of Contraception: _____

Smoking History:
- ☐ Never smoked
- ☐ Smoked and stopped ___yrs ago
- ☐ Currently smoke
____cigarettes/day

Approximate number of alcohol drinks consumed per week:
☐ None ☐ 7-14
☐ <7 ☐ >14

Have you used recreational drugs? ☐ Yes ☐ No

Any history of alcohol problems? ☐ Yes ☐ No

Describe your weekly exercise routine: ______________________________
Describe your typical diet: ____

Have any relatives (mother, father, siblings) had any of the following conditions?

	No	Yes	
1.	☐	☐	Colon Cancer (what age?_____)
2.	☐	☐	Melanoma Skin Cancer
3.	☐	☐	Prostate Cancer before age 70
4.	☐	☐	Breast Cancer (what age?_____)
5.	☐	☐	Uterine Cancer
6.	☐	☐	Ovarian Cancer
7.	☐	☐	Angina or Heart Attack before age 60
8.	☐	☐	Stroke
9.	☐	☐	High Blood Pressure
10.	☐	☐	Diabetes
11.	☐	☐	Osteoporosis

Do you have any of the following problems?

	No	Yes	
1.	☐	☐	A change in your usual headache pattern
2.	☐	☐	Difficulty hearing
3.	☐	☐	Recent sudden vision changes
4.	☐	☐	Pain with swallowing food or liquid
5.	☐	☐	Chest pain at rest or with exertion
6.	☐	☐	Fevers or night sweats
7.	☐	☐	Shortness of breath at low exercise levels
8.	☐	☐	Chronic cough
9.	☐	☐	Unexplained loss of consciousness
10.	☐	☐	Unexplained weight loss
11.	☐	☐	Abdominal pain
12.	☐	☐	Blood in your stools or black stools
13.	☐	☐	Difficulty with urination on a regular basis
14.	☐	☐	Blood in your urine
15.	☐	☐	Trouble with sexual function
16.	☐	☐	Significant joint pain
17.	☐	☐	Loss of interest in daily activities or feelings of hopelessness
18.	☐	☐	Unexplained weakness in any extremity or loss of balance/coordination
19.	☐	☐	Vaginal bleeding after menopause (women only)
20.	☐	☐	Are you dissatisfied with your present weight?