Name _____ Medical Record Number _____
Phone Number _____
Email Address _____ Date of Birth _____

PERSONAL MEDICAL HISTORY			Date and/or Comments
Diabetes	☐ YES	☐ NO	
High blood pressure	☐ YES	☐ NO	
High cholesterol	☐ YES	☐ NO	
Heart attack	☐ YES	☐ NO	
Congestive heart failure (CHF)	☐ YES	☐ NO	
Atrial fibrillation	☐ YES	☐ NO	
Blood clot in leg or lung	☐ YES	☐ NO	
Asthma	☐ YES	☐ NO	
Pneumonia	☐ YES	☐ NO	
COPD/Emphysema	☐ YES	☐ NO	
Cancer	☐ YES	☐ NO	
Thyroid problem	☐ YES	☐ NO	☐ hypo- ☐ hyper-
Osteoporosis	☐ YES	☐ NO	
Bone fractures	☐ YES	☐ NO	
Stroke or TIA	☐ YES	☐ NO	
Seizure	☐ YES	☐ NO	
Migraine	☐ YES	☐ NO	
Depression	☐ YES	☐ NO	
Arthritis	☐ YES	☐ NO	
Gout	☐ YES	☐ NO	
Acid reflux or heartburn	☐ YES	☐ NO	
Gallstones	☐ YES	☐ NO	
Hepatitis or liver cirrhosis	☐ YES	☐ NO	
Ulcer	☐ YES	☐ NO	
Kidney stones	☐ YES	☐ NO	
Anemia	☐ YES	☐ NO	
Other			

MRN

SURGICAL HISTORY			Date and/or Comments
Tonsillectomy	☐ YES	☐ NO	
Thyroidectomy	☐ YES	☐ NO	
Back surgery	☐ YES	☐ NO	
Heart bypass (CABG)	☐ YES	☐ NO	
Heart stent	☐ YES	☐ NO	
Other heart surgery	☐ YES	☐ NO	
Appendectomy	☐ YES	☐ NO	
Gallbladder surgery	☐ YES	☐ NO	
Hernia surgery	☐ YES	☐ NO	
Hip replacement	☐ YES	☐ NO	
Knee arthroscopy	☐ YES	☐ NO	
Knee replacement	☐ YES	☐ NO	
Hysterectomy (ovaries removed)	☐ YES	☐ NO	
Hysterectomy (still have ovaries)	☐ YES	☐ NO	
Tubal ligation	☐ YES	☐ NO	
Breast surgery	☐ YES	☐ NO	
Other			

PREVENTIVE CARE	Year	Result	
Colonoscopy		☐ normal	☐ abnormal
Bone density scan		☐ normal	☐ abnormal
Pap smear		☐ normal	☐ abnormal
Mammogram		☐ normal	☐ abnormal
Abdominal ultrasound for aneurysm *(if you are a man age 65-75 and ever smoked)*		☐ normal	☐ abnormal
Tuberculosis skin test		☐ negative	☐ positive
Pneumonia vaccine			
Tetanus vaccine			
Shingles vaccine			

MRN

HABITS

Do you exercise at least 2½ hours a week?		☐ Yes	☐ No
Have you had a blood transfusion?		☐ Yes	☐ No
Do you always wear seat belts?		☐ Yes	☐ No
Do you have guns in the house?		☐ Yes	☐ No
Did you ever smoke?		☐ Yes	☐ No
Do you currently smoke?	☐ No	☐ Yes	packs/day
Do you drink alcohol?	☐ No	☐ Yes	# of drinks/week
Have you used drugs?	☐ No	☐ Yes	what?

FAMILY HISTORY (check all that apply)

	None	Mother	Father	Sister	Brother	Grand mother	Grand father	Other
Diabetes								
Hypertension								
High cholesterol								
Heart disease								
Stroke								
Breast cancer								
Lung cancer								
Colon cancer								
Prostate cancer								
Ovarian cancer								
Other cancer								
Alzheimer's								
Kidney disease								
Liver disease								
Bleeding								
Blood clots								

MRN

DRUG OR FOOD ALLERGIES

No known allergies ☐

DRUG or FOOD	REACTION

MEDICATIONS

NAME	DOSE	DIRECTIONS

To Email the Form:

STEP 1

- **Save** a copy of this form on your computer using your browser or reader's save function.
- Select the Desktop (or another folder you will remember) to **save the form**

STEP 2

- **Click the Email Form button** below to open your web browser to kp.org
- **Log in** and create a message to your doctor
- Below the message **click on the Browse button**
- **Locate the form** you saved in the computer **and click on it to attach the file**
- **Click the Send button** to send the message and attached form to your doctor
- *(If you used a public computer, make sure to delete the form file from it)*

To Print the Form:

- **Click the Print button** below

EMAIL FORM PRINT