springlife medical
creating health

Your Medical History

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Past Surgeries

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Hospitalizations (not including surgeries)

1. _____
2. _____
3. _____
4. _____
5. _____

Last colonoscopy : _____

Females:

Last Mammogram : _____

Last PAP smear : _____

Family History (please state which family member if any)

Alzheimer's _____
Cancer(type) _____
Coronary artery _____
Cerebrovas. Dis _____
Depression _____
Diabetes _____
Anemia _____
Glaucoma _____
High cholesterol _____
High blood pressure _____
Thyroid _____

Do you smoke : _____

If so for how long?: _____

Initial Risk Assessment (mark if it pertains to you)

Alcohol/Drug Use _____
STDs _____
Domestic Violence _____
Osteoporosis _____

Social History: (mark which pertains to you)

Married _____
Single _____
Divorced _____
Widow _____
Separated _____
Lives Alone _____

Highest Education : _____