# Aurora Clinic

PATIENT'S NAME _____ TODAY'S DATE _____
PERSON FILLING OUT THIS FORM _____ RELATIONSHIP _____

| **MEDICAL PROBLEMS** | NO | YES | IF YES, EXPLAIN |
|---|---|---|---|
| CURRENTLY PREGNANT | | | |
| ULCER DISEASE | | | |
| HIGH BLOOD PRESSURE | | | |
| DIABETES | | | |
| HEART DISEASE | | | |
| HIGH CHOLESTEROL | | | |
| STROKE | | | |
| EPILEPSY / SEIZURE | | | |
| ASTHMA / EMPHYSEMA | | | |
| TUBERCULOSIS / + SKIN TEST | | | |
| LIVER DISEASE / HEPATITIS | | | |
| KIDNEY DISEASE | | | |
| ARTHRITIS | | | |
| BACK INJURY | | | |
| CANCER | | | |
| DEPRESSION / ANXIETY | | | |
| BLEEDING DISORDER | | | |
| HIV | | | |
| OTHERS (SPECIFY) | | | |

**SURGERIES/OPERATIONS (circle)** cesarean section, bypass surgery, ear tubes, tonsillectomy, appendectomy, gall bladder removal, hernia repair, hysterectomy, tubes tied, vasectomy, Other _____
_____

**PROCEDURES: (circle)** colonoscopy, EGD/upper endoscopy, exercise treadmill, angiogram, treatment of cervix
Other _____
_____

**YEARS SCHOOL COMPLETED**_____ **YEARS COLLEGE COMPLETED** _____
**ADVANCED DEGREE** _____
**MARITAL STATUS: SINGLE** _____ **MARRIED** _____ **DIVORCED** _____ **WIDOWED** _____
**NUMBER OF CHILDREN** _____
**OCCUPATION:** _____ **HOBBIES:** _____

| **HEALTH HABITS** | NEVER | YES | IF YES, HOW MUCH? HOW LONG? |
|---|---|---|---|
| SMOKING / TOBACCO | | | |
| SECOND HAND SMOKE EXPOSURE | | | |
| ALCOHOL / LIQUOR | | | |
| DRUG USE | | | |

| **FAMILY MEDICAL HISTORY** | ILLNESSES (IF ANY) |
|---|---|
| FATHER | |
| MOTHER | |
| BROTHER/S | |
| SISTER/S | |
| GRANDFATHER | |
| GRANDMOTHER | |

**REVIEWED/UPDATED:**

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Date | | | | | | | | |
| Initial | | | | | | | | |
| Date | | | | | | | | |
| Initial | | | | | | | | |