

## 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								