DES MOINES UNIVERSITY

Welcome to our practice!!

Please fill out all the following information:

Date _____

Name _____

Date of Birth _____

Signature _____

Sex ☐ Male ☐ Female

Occupation _____

Married ☐ Single ☐ Divorced ☐ Widowed ☐

Do you have an advance directive or a living will?

☐ Yes ☐ No

Please indicate any religious, cultural, or spiritual values you wish to be considered in your health care treatment decision making:

_____

_____

_____

Medications, Allergies, and Immunizations

Please list all current medications. Please include all prescription and over the counter drugs as well as birth control pills, herbal medications, and vitamins.

Medication	**Dosage/How Often**
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____
7. _____	_____
8. _____	_____
9. _____	_____
10. _____	_____

Allergies	**Reaction**
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY (circle yes or no)

DRUG/ALCOHOL USE		
Do you or have you ever smoked?	**YES**	**NO**
If yes, how many cigarettes a day?		
If former smoker, when did you quit?		
If former smoker, how long did you smoke?		
Do you drink alcohol?	**YES**	**NO**
Do you use illegal drugs?	**YES**	**NO**
Do you drink caffeine?	**YES**	**NO**
If yes, how much per day?		
Do you exercise?	**YES**	**NO**
If yes, what activity? CIRCLE Jogging, Running, Cycling, Spinning, Aerobics, Step, Tennis, Racquetball, Weights, Martial Arts, Other		
How many days per week?		
Time/duration (minutes)?		

Current Diet: _____

_____

Do you have any dietary restrictions? Yes No

If yes, please explain: _____

_____

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Past Medical History

Please check if YOU have had any of the following:

Abuse (physical)			Heart Disease		
Abuse (sexual)			Hemorrhoids		
AIDS			High Blood Pressure		
Alcoholism			High Cholesterol		
Alzheimer's			Joint Pain		
Anemia			Kidney Disease		
Anesthesia Complications			Kidney Stones		
Anxiety			Migraines		
Asthma			Osteoporosis		
Back Pain			Pneumonia		
Blood Disorder			Prostate Problems		
Blood Clots			Reflux (gastric)		
Blood Transfusions			Seasonal Allergies		
Cancer			Seizures		
Type:			Sexually Transmitted Disease		
Dementia			Stroke		
Depression			Thyroid Disease		
Diabetes			Urinary Incontinence		
Emphysema			Other		
Eye Disease					
Glaucoma					

Hospitalizations:

Date (mo/year) **Reason**

_____/_____ _____

_____/_____ _____

_____/_____ _____

_____/_____ _____

Comments on Past Medical History:_____

_____

_____

_____

WOMEN ONLY

Gynecologic History

No. of Pregnancies	
Still Births	
Live Births	
Abortions	
Miscarriages	

Past Surgical History

Please check the box if you have had the surgery and then indicate the year if you know it.

SURGERY	Y	YEAR	SURGERY	Y	YEAR
Appendix			Joint		
Back Surgery			Prostate		
Breast Problems / Surgeon			Tonsils		
Ears			Tubal-ligation		
Eyes			Vasectomy		
Foot Trauma			Wisdom Teeth		
Gall Bladder			Other Surgery:		
Heart Bypass					
Hernia Repair					
Hysterectomy					