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:

____

____

____

HPV – Cervical Cancer Date: ____ / ____
(series of 3) Date: ____ / ____
Date: ____ / ____

Hepatitis A Date: ____ / ____
(series of 2) Date: ____ / ____

Hepatitis B Date: ____ / ____
(series of 3) Date: ____ / ____
Date: ____ / ____

Herpes Zoster (shingles) Date: ____ / ____

Tetanus Date of most recent: ____ / ____

Pneumonia Date of most recent: ____ / ____

Additional Vaccines (Please include dates):

______________ Date: ____________

______________ Date: ____________

______________ Date: ____________

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**
If yes, how frequently/how much?		
Do you use illegal drugs?	**YES**	**NO**
If yes, which drug(s)?		
Do you drink caffeine?	**YES**	**NO**
If yes, how much per day?		
Do you have exposure to radon in your home?	**YES**	**NO**
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)?		

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Current Diet: ________________________________

____

Do you have any dietary restrictions? Yes No

If yes, please explain: ________________________

Past Medical History

Please check if YOU have had any of the following:

Condition		Condition	
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	
Arthritis --Osteo or rheumatoid		Osteoporosis	
Asthma		Pneumonia	
Back Pain		Prostate Problems	
Blood Disorder		Reflux (gastric)	
Blood Clots		Seasonal Allergies	
Blood Transfusions		Seizures	
Cancer		Sexually Transmitted Disease	
Type:		Stroke	
Dementia		Thyroid Disease Hyperthyroid/hypothyroid	
Depression		Other	
Diabetes			
Emphysema			
Eye Disease			
Glaucoma			

Hospitalizations:

Date (mo/year) **Reason**

_____/_____ ________________________

_____/_____ ________________________

_____/_____ ________________________

Comments on Past Medical History:____________

____

____

WOMEN ONLY

Age at 1st period?	
Age at menopause?	
No. of Pregnancies	
Still Births	
Live Births	
Abortions	
Miscarriages	

History of Testing

TEST	DATE MO.	DATE YEAR	NORMAL RESULTS	ABNORMAL RESULTS
Bone Density Scan				
Chest X-Ray				
Cholesterol				
Colonoscopy				
Dental Exam				
EKG				
Eye Exam				
Stress Test				
TB Test				
Men ONLY				
PSA				
Prostate Exam				
Aneurysm Screen (smoker, 65-75)				
Women ONLY				
Pap Smear				
Mammogram				

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					

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Family History

Family Member	Age if Living	Age Deceased	Cause of Death
Mother			
Father			
Maternal Grandmother			
Paternal			
Maternal Grandfather			
Paternal			
Siblings			
Children			

Use the key to indicate if any of your family members currently have or have had any of the conditions/diseases listed.

M=Mother F=Father B=Brother
S=Sister C=Child

DISEASE/COND.	M	F	B	S	C
Alcoholism					
AIDS					
Alzheimer's					
Anemia					
Anesthesia Problems					
Anxiety					
Asthma					
Bleeding Disorders					
Blood Clots					
Cancer					
Type:					
Depression					
Diabetes					
Emphysema					
Glaucoma					
Heart Disease					
Hemorrhoids					
High Cholesterol					
High Blood Pressure					
Kidney Disease					
Migraines					
Osteoporosis					
Seizures					
Stroke					
Thyroid Disease					
Tuberculosis (TB)					

Use the key to indicate if any of your family members currently have or have had any of the conditions/diseases listed.

GMM=Maternal grandmother
GFM=Maternal grandfather
GMP=Paternal grandmother
GFP=Paternal grandfather

DISEASE/COND.	GMM	GFM	GMP	GFP
Alcoholism				
AIDS				
Alzheimer's				
Anemia				
Anesthesia Problems				
Anxiety				
Asthma				
Bleeding Disorders				
Blood Clots				
Cancer				
Type:				
Depression				
Diabetes				
Emphysema				
Glaucoma				
Heart Disease				
Hemorrhoids				
High Cholesterol				
High Blood Pressure				
Kidney Disease				
Migraines				
Osteoporosis				
Seizures				
Stroke				
Thyroid Disease				
Tuberculosis (TB)				

Additional Comments on Family History:______________

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