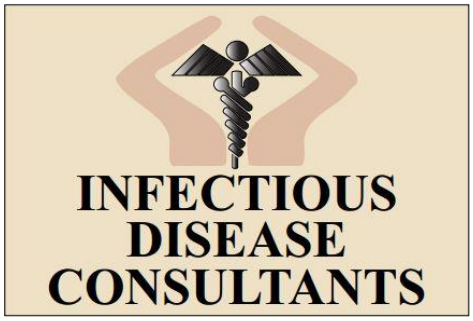

Initial History Form

Welcome to Infectious Disease Consultants. In order for us to get to know you better and help you with any problems you might have, please fill out this health questionnaire to the best of your knowledge. If you are not sure, please mark the question with a question mark and we will discuss it with you at your appointment.

Name: _____ Todays Date: __/__/____
Date of Birth: __/__/____ Age: _____ Height: _____ Weight: _____

Who is your primary care provider? (Family or primary doctor)
Name: _____
Phone #: _____

Who referred you to our clinic? (If different from above)
Name: _____
Phone #: _____

To whom do you want us to send your records.
Name: _____
Phone #: _____

What is your preferred pharmacy?
Name: _____
Address: _____
Phone #: _____

If we try to reach you, may we leave a message (including information related to your diagnosis?) on your voicemail/ answering machine?

□ No □ Yes, preferred number: (___) ___-____

What is your preferred way to receive medical records/lab results?

____ Mail **Address: _____**
____ Phone **Number: (___) ___-____ This is my: Home □ Work □ Cell □**
____ Email **Address: _____**
It is OK □ Not OK □ to email actual medical records (There are risks to confidentiality involved in electronic communications.)

In your own words, why are you here to see an infectious disease physician?

_____
_____
_____

What medications are you taking (including vitamins, herbs, over-the-counter pills?) Additional space on back.

Name of Drug	Dose	Taken How Often	For what purpose (Diagnosis)

Have you ever had allergies to medications? Yes □ No □

Drug	Reaction

Please list all of your medical problems (hypertension, diabetes, etc)

Medical Problem	When diagnosed

Please list all of your surgeries and hospitalizations

Surgery, Hospitalization	Dates (approx.)	Where treated

Have you had these vaccinations?

Vaccine	Last Date	Vaccine	Last Date
Pneumovax/Prevnar 13		Hepatitis A	
Influenza		Hepatitis B	
Tetanus (TDAP)		Chicken Pox/Shingles	

With whom do you live with? _____
Who knows about your condition? _____
Is there anyone who should not know? _____
Where do you live now? _____ Where were your born? _____
Where have you lived previously? _____
Where have you traveled outside the US? _____
What pets do you have? _____
Relationship status: Single□ Married □ Partnered □ Widowed □
Are you currently working? Yes □ No □
What is/was your occupation? _____
Are you currently pregnant? Yes □ No □ Are you currently trying to get pregnant? Yes □ No □

Substance Use

Do you smoke cigarettes? **Never □** **No longer use□** **Quit _____** **Yes □** **Average _____ cigs/day**

How old were you when you started smoking? _____

Do you drink alcohol? **Never □** **No longer use□** **Quit _____** **Yes □** **Average _____ drinks/day**

Do you drink products with caffeine? Yes □ **No □** **If so, Average _____ drinks/day**

Have you ever injected IV drugs? Yes □ **No □**

Have you ever used illicit drugs (ie. Cocaine, etc)? Yes □ **No □** **If so, what? _____**

Family History

Have any of your blood relatives had any of the following?

Medical Condition	Check if Yes	Relative and Approximate Age
High Blood Pressure		
Heart Disease, MI, Bypass Surgery		
Hyperlipidemia (High Cholesterol)		
Stroke		
Diabetes		
Cancer		
Kidney Disease, Dialysis		
Alzheimer's Disease		
Autoimmune Disease (Lupus, Thyroid Dis. Rheumatoid arthritis, etc.)		
Others		

STD History: **None □**

Have you had any of the following? If so when were you treated?

Syphilis		Herpes Simplex	
Gonorrhea		PID	
Chlamydia		Genital Warts	

Is there anything else we need to know?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____