

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							