Hudson's Bay Medical Group, Inc P.S.
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Patient Name: _____ Date: _____ Doctor: _____

Date of Birth: _____ Place of Birth: _____ Race/Nationality: _____
Religion: _____ Education: _____ Occupation: _____

Marital Status/ Living Situation:

Married: _____ Single: _____ Divorced: _____ Widowed: _____ Domestic Partner: _____
Live: Alone: _____ Family: _____ Assisted Living: _____ Other: _____
Spouse/Partner's Name: _____ Occupation: _____
Children (List Sex/Birth Year): _____

Habits (Circle Y=Yes, N=No):

Do you use Alcoholic Beverages? **Y / N** Type: _____ Amount/Frequency: _____ Former: _____
Do you use Tobacco? **Y / N** Type: _____ Amount/Frequency: _____ Former: _____
Do you use Recreational Drugs? **Y / N** Type: _____ Amount/Frequency: _____ Former: _____
Do you drink Caffeinated Beverages? **Y/N** Type: _____ Amount/Frequency: _____ Former: _____
Do you Exercise? **Y / N** Type: _____ Frequency: _____

Immunization Dates:

Tetanus _____
Pneumonia _____
Hepatitis A _____
Hepatitis B _____
MMR _____
Polio _____
Tuberculosis Skin _____
Influenza _____
Other: _____ _____

Transfusion: _____
Travel History outside North America: _____
_____
Hazardous Exposure: Secondhand Smoke: _____
Asbestos: _____ Other: _____
Risk of HIV, Hepatitis, STDs: _____
History of Domestic Violence: _____
History of Childhood Abuse: _____
Wear Sunscreen: Yes / No Wear Seatbelt: Yes / No

Surgeries: Have you had the following surgeries (R=Right, L=Left, B=Both)?

Surgery:	**Date:**	**Surgery:**	**Date:**
Appendectomy	_____	Hernia: Location	_____
Back Surgery:	_____	Hysterectomy	_____
Neck	_____	Abdominal _____ Vaginal _____	
Low Back	_____	Ovaries left in _____ Ovaries out: **R / L / B**	
Breast Biopsy: **R / L / B**	_____	Tubal Ligation	_____
Breast Implant: **R / L / B**	_____	Joint/Bone Surgery	_____
Mastectomy: **R / L / B**	_____	Location _____ Side: **R / L / B**	
Carotid Artery Surgery	_____	Prostate Surgery	_____
Cataracts: **R / L / B**	_____	Abdominal _____ Urethral _____	
LASIK Eye Surgery: **R /L /B**	_____	Tonsillectomy	_____
Gallbladder:	_____	Vasectomy	_____
Laparoscopic ____	_____	Other:_____	_____
Open _____	_____	_____	_____

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Past Medical History: Please circle if you **Have Had** or **Have** any of the following disorders/diagnoses.

Acne
ADD (attention deficit disorder)
ADHD (Attention deficit/ Hyperactivity disorder)
Alcoholism
Alcoholism, in recovery
Allergic Rhinitis
Environmental Allergies
Pollen / Cats / Dogs / Dust Mites / Other _____
Alzheimer's Disease
Anemia
Anemia: Iron Deficiency
Anticoagulation
Anxiety
Arthritis: Degenerative/Osteo
What Joint? _____
Arthritis: Rheumatoid
Asthma
Atrial Fibrillation
Bee Sting Allergy
Bipolar Disorder
Cancer: Type: _____
Colitis: Type: _____
Coronary Artery Heart Disease
Carpal Tunnel Syndrome
Congestive Heart Failure
Colon Polyps
Constipation
COPD (Chronic Obstructive Lung Disease)
Depression
Depression/ Anxiety
Dermatitis
Diabetes, Type 1
Diabetes, Type 2
Disc Disease:
Cervical
Lumbar
Diverticulosis
Dizziness
Edema
Emphysema
Endometriosis
Erectile Dysfunction
GERD/Heartburn
Gout
Headache
High Blood Pressure
High Cholesterol/Lipids
Hyperglycemia/Sugar
Hypogonadism
Incontinence: Stress/ Urge
Irritable Bowel Syndrome:
Symptom: Diarrhea/ Constipation/ Pain
Insomnia
Interstitial Cystitis
Kidney Stones
Kidney Disease
Liver Disease
Low Back Pain
Menopause
Migraine
Neck Pain
Neuropathy
Osteopenia
Osteoporosis
Peripheral Artery Disease
Polycystic Ovary Syndrome
Prostate Enlargement
Psoriasis
Pulmonary Embolism
Restless Leg Syndrome
Rosacea
Sciatica
Seborrhea/ Seborrheic/ Dermatitis
Seizure Disorder
Shingles
Sleep Apnea
Stroke
Thyroid Disorder:
Overactive/ Underactive/ Nodule
Transient Ischemic Attack
Tremor
Tuberculosis
Ulcer: Where? _____
Urinary Tract Infections
Vein Clot
Vertigo
OTHER DIAGNOSES:
_____
_____
_____
_____

Family Medical History: **** Has anyone in your family had? For Aunts/Uncle/Grandparents, Please indicate if they are Mother or Father's side, and how old when they got the disease. ****

Disease:	**Family Member:**	**Disease:**	**Family Member:**
Cancer:	_____	Coronary Artery Disease/ Heart Attack:	_____
Breast	_____	Kidney Disease	_____
Colon	_____	Depression	_____
Ovary	_____	Anxiety	_____
Prostate	_____	Alcoholism	_____
Other	_____	Thyroid Disease:	_____
Colon Polyps	_____	Type:	_____
Diabetes	_____	Alzheimer's Disease	_____
High Blood Pressure	_____	Migraines	_____
High Cholesterol	_____	Other: _____	_____
Stroke	_____		

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Procedures: Have you had: **CT's, US's, MRI's, EKG's** etc? Please give details such as **L or R**, and **area of body** (ex. R leg CT).

Procedures:	**Date:**	**Result:**

Other physicians you are seeing:	**Type:**

Medication Allergies:	**Reaction:**

Pharmacy Name: _____ **Phone/Fax: _____**

Medications: Please list all prescription and nonprescription medications.

Supplements/OTC:

Medication:	**Dose:**	**Dose per day:**	**Who Prescribed:**