

***Personal and Family History***

**Please print. This information becomes part of your Confidential Medical Record.**

Patient Information			
First Name	Last Name	Date of Birth	Today's Date
Address		<input type="checkbox"/> Male	<input type="checkbox"/> Female
City	State	ZIP Code	
Home Phone ( )	Work Phone ( )	<input type="checkbox"/> Married	<input type="checkbox"/> Divorced
		<input type="checkbox"/> Single	<input type="checkbox"/> Other
Type of work		Religion (optional)	
Previous Physician			

Weight _____ current weight _____ usual weight _____ gained in the last year _____ lost in the last year	Height _____ ft. _____ in.	Smoking/Tobacco _____ packs per day _____ no. of years _____ year stopped Chew Tobacco? <input type="checkbox"/> yes <input type="checkbox"/> no
Coffee _____ # cups per day	Drugs Marijuana? <input type="checkbox"/> yes <input type="checkbox"/> no Other? <input type="checkbox"/> yes <input type="checkbox"/> no	Alcohol – number of drinks per: _____ day _____ week _____ month

Medications (Prescription, Herbal, Over The Counter)			
Name of Medication	Dosage	Name of Medication	Dosage
1		5	
2		6	
3		7	
4		8	

Previous Surgeries		Previous Major Illness, Injury, Hospitalization	
Surgery	Date	Illness/Injury/Hospitalization	Date
1		1	
2		2	
3		3	
4		4	

**Cardinal** Medical Center

204 S Santa Fe Avenue,  
 Vista, CA 92084-6002  
 Ph: 760-941-8888  
 Fax: 760-650-3222

<b>Family History</b>			
<b>Family Member</b>	<b>Age, If Alive</b>	<b>Age at Death</b>	<b>Medical Problems/Cause of Death</b>
Father			
Mother			
Brothers (#____)			
Sisters (#____)			
Children (#____)			

<b>Women Only</b>			
Date Last Menstruated	Period Every _____ days	# Pregnancies	# Miscarriages
Birth Control Method (if any)	Date of Last Pap Smear	Date of Last Mammogram	

Signature	Print Name	Date
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