Western Washington Medical Group
Everett Family Medicine

Name _____ Date _____

Nick Name _____ DOB _____

Occupation _____ Marital Status _____

Current Medications and Dosing:

_____
_____
_____

Do you have any medical conditions? Yes No
If so, please explain_____
_____
_____

Surgeries:

_____ Year ____ _____ Year ____
_____ Year ____ _____ Year ____
_____ Year ____ _____ Year ____

List any hospitalizations:

_____
_____

Allergies to Medications and Reactions, Please List:

_____
_____
_____

When was your last Pap?_____ NA _____

When was your last Mammogram? _____/ Where _____ NA ___

When was your last Dexa Scan? _____/ Where _____ NA____

When was your last Colonoscopy _____ / Where _____ NA _____

Who lives in your household with you? _____

Western Washington Medical Group
Everett Family Medicine

Do you smoke/chew Yes No #_____/day

Any blood related males under 55 yrs. of age had a heart attack? Yes No

Any blood related females under 65 yrs. of age had a heart attack? Yes No

Do you use recreational drugs? Yes No if yes, which ones _____

Have you ever smoked / use chew Yes No Year Quit _____

Coffee/Caffeine Yes No #cups per day _____

Alcohol Yes No #_____/day, week, month

Exercise Yes No if so, what? _____
#_____ minutes/day #_____/week

Your exposure to the sun is: Rare Occasional or Frequent

Has any blood relation in your family had the following?
If yes, please list relation and age

Cancer: Colon _____
Breast _____
Prostate _____
Ovarian _____
High Blood Pressure _____
Heart Attack _____
Stroke _____
Diabetes _____