



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? _____

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 _____