SOUTHWEST INFECTIOUS DISEASE ASSOCIATES

PATIENT HISTORY

Patient Name:_____ Date of Birth:_____

Reason for today's visit:_____ Occupation:_____

Allergies: (Please include onset of allergy and what type of reaction symptoms you have. If no allergies, please write "none.")

_____

_____

Please list any major health events, hospitalizations or surgeries you have had._____

_____

Please list your current medical problems. (Include date of onset)_____

_____

Lifestyle Assessment: Please circle the appropriate answer to the below questions.

Do you smoke?	Never	Previously	Occasionally	Daily
Do you consume alcohol?	Never	Occasionally	Daily	
Do you use recreational drugs?	Never	Occasionally	Daily	
Have you engaged in high risk sexual behavior since your last visit?	I have	I have not		

If any of the following illnesses have been

Y/N	Please specify exact diagnosis	Date of diagnosis and family member
	Heart Disease or High Blood Pressure	
	Lung Disease	
	Diabetes	
	Arthritis	
	Stroke or Neurological Disease	
	Lupus or Other Auto-Immune Disease	
	Blood Transfusion	
	Hepatitis or Liver Disorder	
	Gastrointestinal Disorder	
	Mental Illness	
	Cancer or Leukemia	
	Kidney Disease	
	Skin Condition/Rash	
	Sexually Transmitted Disease or HIV+	
	Tuberculosis	

(continued on back side of form)

Have you received any of the following immunizations?

	Date	Where
Pneumonia(Pneumovax)		
Influenza		
Hepatitis B		
Tetanus		
Other:		