PERSONAL HEALTH INFORMATION

9 Commons Street
Rutland, VT 05701
(802) 779-7522 Fax: (802) 735-9662

Patient Name:_____ Date of Birth:_____

MEDICAL HISTORY: *Have you ever been diagnosed with any of the following:* *(Please check ALL that apply)*

[ ] High Blood Pressure
[ ] Heart Disease
[ ] Asthma/Lung disease
[ ] Glaucoma
[ ] Stroke or TIA's
[ ] Thyroid Disorder
[ ] Seizures
[ ] Alzheimers/Dementia
[ ] Mental Illness
[ ] Hereditary Disease
[ ] Drug or Alcohol abuse
[ ] Diabetes
[ ] Kidney or Bladder Disorders
[ ] Hernia
[ ] Arthritis
[ ] Skin Disorder
[ ] Ear Disorder
[ ] Muscular Disorder
[ ] Liver or Gall Blader disorders
[ ] Head injuries/Headaches
[ ] Joint Replacements
[ ] Blood Clots
[ ] Osteoporosis
[ ] Nerve Disorders
[ ] Cancer (type):_____
[ ] Other _____

FAMILY MEDICAL HISTORY: *(Please check All that apply and who it pertains to)*

	Family Member		Family Member
[ ] High Blood Pressure		[ ] Depression/Anxiety	
[ ] Heart Disease		[ ] Hepatitis A, B, C or HIV	
[ ] Aortic Aneurysm		[ ] Breast Cancer	
[ ] Diabetes		[ ] Prostate Cancer	
[ ] Stroke		[ ] Colon Cancer/Polyps	
[ ] Thyroid Disorder		[ ] Other Cancers (type):	
[ ] Alzheimers/Dementia			

Past Surgeries:

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

Past Hospitalizations:

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

DATE OF LAST MAMMOGRAM:_____ **DATE OF LAST GYNECOLOGY EXAM:**_____

DATE OF LAST EYE EXAM:_____ **DATE OF LAST DENTAL EXAM:**_____

DATE OF LAST WELLNESS/PREVENTICON EXAM:_____

DATE OF LAST COLONOSCOPY OR COLOGUARD:_____

Allergies to Medications (?) : _____

Allergic to Latex? Yes [ ] No [ ]

Current Medications: *Include dosage and directions, as well as Over-the-Counter Supplements*

Medication	Dose	Frequency	Special Instructions

DATE OF LAST IMMUNIZATIONS: *(for children, please attach copy of immunization record)*

Date		Date	
_____	Flu Vaccine	_____	Tetanus/Tdap/TD/DTaP
_____	Meningitis	_____	Pneumonia Vaccine
_____	Human papilomavirs	_____	Pneumovax
_____	Hepatitis B	_____	Prevnar
_____	Hepatitis A	_____	PPD (tuberculosis skin test)
_____	Polio	_____	Measles, Mumps, and Rubella (MMR)
_____	Shingrix	_____	Travel Vaccines (Typhoid,yellow fever, malaria)

COVID - 19 VACCINE		**Date**	
[ ]	Pfizer	_____	1st dose
[ ]	Moderna	_____	2nd dose
[ ]	J & J	_____	Booster

Other Pertinent Information:

_____

_____