Donna Johnston, MD

Name:_____ Age:___ Today's Date:_____

Past Medical History: Do **YOU** have any of the following?

__Allergies/hay fever
__Anemia
__Arthritis
__Asthma
__Bowel irregularity
__Depression
__Dizziness
__Diabetes
__Erectile dysfunction
__Gout
__Headaches/migraines
__Heart Murmur
__High cholesterol
__Hypertension
__Menstrual dysfunction
__Nervousness/anxiety
__Prostate disease
__Seizure disorder
__Thyroid disease
__Ulcer/GERD
__Other:_____
_____
_____
_____

Date of last immunizations:
__Flu vaccine
__Tetanus
__Pneumonia
__Shingles
__other: _____

Past hospitalizations or surgeries with dates:

_____

_____

do you still have your gallbladder? yes no ; appendix? yes no

Habits/risk factors: smoke now? yes no ever smoke in past? yes no
packs per day: _____ how long?_____
Alcohol? yes no ;Type:_____; Amount:_____
Street drugs? yes no; Type:_____

**Men**: Date of last Prostate exam?_____ Date of last PSA?_____

**Women**:

Date of last period: _____ have you had a hysterectomy? yes no
Date of last pap smear: _____ was it a partial or full hysterectomy:_____
Date of last mammogram: _____ Do you do self breast exam monthly: yes no
Do you see gynecologist? yes no who? _____
Type of birth control: _____

**Family History**: What runs in your family:

mother:_____
father:_____
sibling:_____
father's parents:_____
mother's parents:_____
other:_____

**Advance Directives**: Do you have a living will? yes no (if yes, please provide a copy)

Medications: (attach list if needed) Allergies: _____