Kate McCaffrey, D.O.
Redwood Osteopathy, Inc.

Date_______________

Last name_______________________First name_______________________DOB ______________

Occupation/ Employer____

HOSPITALIZATIONS/SURGERIES (if an overnight stay was involved and excluding “normal” pregnancies)

Year	Illness/Operation	Year	Illness/Operation

MEDICAL & FAMILY HISTORY (please note if you or a blood relative have had any of these conditions)

Illness	Self	Relation	Illness	Self	Relation
1. Recent weight loss			16. Heart valve disorder		
2. Migraine headaches			17. Diabetes		
3. Epilepsy/ convulsions			18. Thyroid		
4. Eye disease (excl. glasses)			19. Stomach Ulcer		
5. Hearing disorder			20. Bowel problems		
6. Recurrent nose bleeds			21. Liver disease/ hepatitis		
7. Sinus/ throat infections			22. Kidney/ bladder problem		
8. Lung disease			23. Neurological		
9. Angina - chest pain			24. Arthritis		
10. Heart attack			25. Osteoporosis		
11. High blood pressure			26. Accidents/ traumas		
12. High cholesterol			27. Bleeding disorder		
13. Stroke			28. Blood transfusions		
14. Cancer			29. Anemia		
15. Adrenal issues			30. Alcohol/ drug abuse		

Illness (continued)	Self	Relation	Illness (continued)	Self	Relation
31. Depression			33. Mental illness		
32. Psoriasis/ eczema			34. Hair loss		

35. Fractures/ sprains	Self
Notes:	

36. Dental work	Notes	Self
a. Bridge		
b. Cavities		
c. Teeth extracted		
d. Orthodontia		
e. Splint/ night guard		
f. Root canal/ crown		

PAST MEDICAL/ TRAUMA HISTORY ____

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MEDICATIONS/SUPPLEMENTS

Medication	Dose	Times/Day	Medication	Dose	Times/ Day

DIET	**EXERCISE**

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DRUG ALLERGIES

Drug	Reaction

EVER CONSUMED

	Yes	No	# of weeks	# of years
1. Cigarettes				
2. Alcohol				
3. Coffee / tea				
4. Diet soda				
5. Other				

NOTES ____

WOMEN ONLY

Date of last menstrual cycle ____________________________ Reg. Cycle: Yes / No

Are you using birth control? ____________________________

# of pregnancies _________ # of births _________ # of miscarriages _________ # of abortions _________

YR/ Last Pap Test _________ YR/ Last Breast exam _________ YR/ Last Mammogram _________

Other problems or symptoms for which you are seeing another doctor and would like to discuss: