



Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

What is your reason for visit? _____

SOCIAL HISTORY

- 1. Do you drink Alcohol? Y N How much? _____ How long? _____ If in past, when quit? _____
2. Do you drink Caffeine? Y N How much? _____ How long? _____ If in past, when quit? _____
3. Do you or have you taken any drugs other than prescription medications? Y N What kind? _____ When? _____
4. Employment status: Full Time Part Time Student Unemployed Retired Disabled Self-employed
5. Marital status: Married Divorced Widowed Single
6. Does your work require heavy lifting? Y N If yes, explain _____
7. Are you exposed to hazardous substances at work? Y N If yes, explain: _____
8. Do you experience stress related to your work? Y N If yes, explain: _____
9. Are you currently pregnant? Y N How far along? _____ # of pregnancies? _____ Complications?: _____
10. Do you smoke/chew tobacco? Y N How much? _____ How long? _____ If in past, when quit? _____

FAMILY HISTORY

Table with 5 columns: RELATION, AGE, STATE OF HEALTH (EXCELLENT, GOOD, FAIR, POOR), AGE AT DEATH, CAUSE OF DEATH. Rows include Father, Mother, Brothers, and Sisters.

Please check if any blood relatives have had any of the following:

- Arthritis Who: _____
Lung Disease Who: _____ Type: _____
Cancer Who: _____ Type: _____
Diabetes Who: _____
Other _____ Who: _____
Heart Disease Who: _____
Stroke Who: _____
High Blood Pressure Who: _____
Kidney Disease Who: _____ Type: _____
Tuberculosis Who: _____

PERSONAL MEDICAL HISTORY - Please check for any conditions you as the patient have had.

- AIDS, Alcoholism, Anemia, Anorexia/Bulimia, Appendicitis, Arthritis, Asthma, Bleeding Disorders, Blood Clots, Breast Lump, Bronchitis, Cancer: Type _____, Cataracts, Chemical Dependency, Chicken Pox, Diabetes, Emphysema, Epilepsy, Glaucoma, Goiter, Gonorrhea, Gout, Heart Attack, Heart Disease, Hepatitis: Type _____, Hernia: Type _____, Herpes: Type _____, High blood pressure, High Cholesterol, HIV Positive, Kidney Disease, Liver Disease, Lung Disease, Low blood pressure, Migraine Headaches, Miscarriage, Mononucleosis, Multiple Sclerosis, Mumps, PACEMAKER, Pneumonia, Peripheral Vascular Disease, Prostate Problem, Psychiatric Care, Rheumatic Fever, Stroke, Suicide Attempt, Thyroid Problems, Tuberculosis, Ulcers, Vaginal Infections, Venereal Disease, Other _____

Have you ever had a blood transfusion? Y N When? _____

ALLERGIES To medications or substances

Name of medication or substance:

Reaction:

X-RAY DYE: Y N reaction: _____ LATEX ALLERGY: Y N reaction: _____

SURGICAL HISTORY

DATE	HOSPITAL	PROCEDURE PERFORMED

REVIEW OF SYSTEMS

GENERAL

- Chills
- Dizziness
- Fever
- Headache
- Loss of sleep
- Loss of weight
- Nervousness
- Numbness
- Depression
- Fainting
- Forgetfulness
- Sweats

MUSCULOSKELETAL

Pain, weakness, numbness in:

- Arms
- Back
- Feet
- Hands
- Hips
- Legs
- Neck
- Shoulders

SKIN

- Bruise easily
- Itching
- Change in moles
- Sore that won't heal
- Hives
- Rash
- Scars

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

GASTROINTESTINAL

- Appetite poor
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Heartburn
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

CARDIOVASCULAR

- Chest pain
- Irregular heart beat
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

EYE, EAR, NOSE, THROAT

- Bleeding Gums
- Blurred Vision
- Contact Lenses
- Crossed Eyes
- Dentures/Partials
- Difficulty Swallowing
- Double Vision
- Earache
- Ear Discharge
- Glasses/Contacts
- Hay Fever
- Hoarseness
- Loss of Hearing
- Nosebleeds
- Ringing in ears
- Sinus problems
- Vision - flashes
- Vision - halos

RESPIRATORY

- Chronic Cough
- Productive Cough
- Bloody Cough
- Wheezing
- Shortness of Breath

MEN only

- Breast lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Other _____

WOMEN only

- Abnormal Pap Smear
- Bleeding between periods
- Breast lump
- Extreme menstrual pain
- Hot flashes
- Nipple discharge
- Painful intercourse
- Vaginal discharge
- Other _____
- Date of last menstrual period _____
- Date of last Pap Smear _____
- Date of last mammogram? _____

MEDICATIONS

MEDICATIONS

MG

How many times per day?

Do you take any of these medications daily: Aspirin, Plavix, Coumadin, other anti-Coagulants _____? **Y N**

Name of local Pharmacy: _____ City: _____

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor(s) or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Patient/Guardian Signature

Date

Physician Signature

Date