

Today's date \_\_\_\_\_

Patient's Name \_\_\_\_\_ Sex  F  M Age \_\_\_\_\_ Birthdate \_\_\_\_\_

Marital Status:  S  M  W  D  Sep.  Partner Race \_\_\_\_\_ Education (grade completed) \_\_\_\_\_

Occupational Status:  Homemaker  Unemployed  Student  Employed (describe) \_\_\_\_\_

Medications taken regularly/dose \_\_\_\_\_

\_\_\_\_\_

**Past hospitalizations, surgeries, dates & obstetric history**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Ongoing Medical Problems**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Allergies (to drugs such as penicillin)**

\_\_\_\_\_  
 \_\_\_\_\_

**IMMUNIZATIONS** Have you had the following?

Tetanus            Y    N    Dates \_\_\_\_\_  
 Hepatitis        Y    N    Dates \_\_\_\_\_  
 Flu                Y    N    Dates \_\_\_\_\_  
 Pneumovax      Y    N    Dates \_\_\_\_\_  
 Bad reaction to a shot?    Y    N    \_\_\_\_\_  
     If so, which one?            \_\_\_\_\_

**PERSONAL HABITS**

	Y	N	AMOUNT
Smoke	Y	N	_____
Drink Alcohol	Y	N	_____
Use Street Drugs/Marijuana	Y	N	_____
Drink Coffee/Cola	Y	N	_____
Exercise	Y	N	_____
Use Sunscreen	Y	N	_____
Domestic Abuse	Y	N	_____
Seat Belt	Y	N	_____
Guns in the house	Y	N	_____

**Have you or any of your family (including parents, brothers, sisters, grandparents) had any of the following?**

	RELATIONSHIP (IF YES)		RELATIONSHIP (IF YES)
Glaucoma .....	Y _____	N	Ulcer (stomach or duodenal) ..... Y _____ N
Asthma .....	Y _____	N	Diabetes ..... Y _____ N
Chronic bronchitis or emphysema .....	Y _____	N	Thyroid disorder ..... Y _____ N
Heart disease .....	Y _____	N	Arthritis (pain or stiffness in joints) ..... Y _____ N
High blood pressure .....	Y _____	N	Infectious mononucleosis (mono) ..... Y _____ N
Phlebitis (blood clots in legs) .....	Y _____	N	Rheumatic fever ..... Y _____ N
Pneumonia .....	Y _____	N	Sexually Transmitted Disease ..... Y _____ N
Stroke .....	Y _____	N	Epilepsy (seizures or convulsions) ..... Y _____ N
Tuberculosis .....	Y _____	N	Alcohol/drug problems ..... Y _____ N
Anemia or low blood count.....	Y _____	N	Mental Health Problems (depression/anxiety, etc.) ... Y _____ N
Bleeding problems .....	Y _____	N	Cancer ..... Y _____ N
Colitis .....	Y _____	N	Type of Cancer _____
Kidney or bladder infections .....	Y _____	N	Other serious illnesses (describe) _____
Liver disease or hepatitis .....	Y _____	N	_____

**PERSONAL HEALTH** Are you troubled by any of the following?

**1. GENERAL**

Extreme tiredness Y N  
 Unexplained weight loss Y N  
 Extreme thirst Y N  
 Lumps or swelling - where? Y N  
 \_\_\_\_\_  
 Other \_\_\_\_\_

**2. SKIN AND HAIR**

Repeated skin rash Y N  
 Repeated sores Y N  
 Moles that have changed size and color Y N  
 Other \_\_\_\_\_

**3. EYES, EARS, NOSE, AND THROAT**

Loss of hearing Y N  
 Ringing in your ears Y N  
 Disturbance in vision Y N  
 Repeated nose bleed Y N  
 Long term nasal stuffiness or drainage Y N  
 Severe dental problems Y N  
 Hoarseness or voice changing Y N  
 Trouble swallowing Y N  
 Other \_\_\_\_\_

**4. HEART, LUNGS, AND CIRCULATION**

Chronic cough Y N  
 Coughing up blood Y N  
 Abnormal chest x-ray Y N  
 Wheezing Y N  
 Chest pain Y N  
 Shortness of breath Y N  
 Irregular heart beat Y N  
 Heart murmur Y N  
 Leg cramps while walking Y N  
 Ankle swelling Y N  
 Other \_\_\_\_\_

**5. STOMACH & BOWELS**

Poor appetite Y N  
 Heartburn Y N  
 Repeated abdominal pain Y N  
 Tarry (black) stool Y N  
 Frequent nausea or vomiting Y N  
 Changes in bowel movements Y N  
 Constipation Y N  
 Frequent diarrhea Y N  
 Rectal bleeding Y N  
 Other \_\_\_\_\_

**6. KIDNEY, BLADDER, REPRODUCTIVE**

Difficult or painful urination Y N  
 Urination more than once a night Y N  
 Trouble holding urine Y N  
 Repeated bladder or kidney infection Y N  
 Blood in urine Y N  
 History of kidney stone Y N  
 Problem with sex function Y N  
 Sores or discharge Y N  
 Problems having children Y N  
 Sexually active Y N  
 If yes, type of contraception used \_\_\_\_\_  
 Other \_\_\_\_\_

**7. SKELETON AND JOINTS**

Swollen or painful joints Y N  
 Gout Y N  
 Back trouble Y N  
 Difficulty walking Y N  
 Bursitis or tendonitis Y N  
 Other \_\_\_\_\_

**8. NERVOUS SYSTEM**

Frequent or severe headaches Y N  
 Loss of balance Y N  
 Unexplained dizziness Y N  
 Fainting (blackout) Y N  
 Head injury Y N  
 Twitching or tremors (shaking) Y N  
 Numbness or tingling in hands or feet Y N  
 Stress or nervousness Y N  
 Feeling depressed Y N  
 Thoughts of suicide Y N  
 Trouble concentrating or remembering Y N  
 Have you had counseling? Y N  
 Do you desire counseling? Y N  
 Other \_\_\_\_\_

**9. OTHER PROBLEMS/CONCERNS**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**WOMEN ONLY**

Irregular periods Y N  
 Severe cramps Y N  
 Last Pap smear date \_\_\_\_\_  
 Abnormal smear date \_\_\_\_\_  
 Last mammogram date \_\_\_\_\_  
 Abnormal mammogram date \_\_\_\_\_  
 Mammogram received at \_\_\_\_\_

**MEN ONLY**

Swelling or tenderness of the scrotum or testicles Y N  
 Prostate trouble Y N  
 Vasectomy Y N

Patient signature \_\_\_\_\_

Physician comments:

Physician signature \_\_\_\_\_