

Patient Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Date of Last Physical Examination \_\_\_\_\_

What is the reason for your visit? \_\_\_\_\_

# Symptoms

Check ( ✓ ) symptoms you currently have or have had in the past year:

### GENERAL

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

### MUSCLE / JOINT / BONE

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

### GENITO-URINARY

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

### GASTROINTESTINAL

- Poor appetite
- Bloating
- Bowel changes
- Constipation
- Diarrhea
- Excessive hunger
- Excessive thirst
- Gas
- Hemorrhoids
- Indigestion
- Nausea
- Rectal bleeding
- Stomach pain
- Vomiting
- Vomiting blood

### CARDIOVASCULAR

- Chest pain
- High blood pressure
- Irregular heart beat
- Low blood pressure
- Poor circulation
- Rapid heart beat
- Swelling of ankles
- Varicose veins

### EYE, EAR, NOSE, THROAT

- Bleeding gums
- Blurred vision
- Crossed eyes
- Difficulty swallowing
- Double vision
- Earache
- Ear discharge
- Hay fever
- Hoarseness
- Loss of hearing
- Nosebleeds
- Persistent cough
- Ringing in ears
- Sinus problems
- Vision – Flashes
- Vision – Halos

### SKIN

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

### 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: \_\_\_\_\_

Have you had a mammogram? \_\_\_\_\_

Are you pregnant? \_\_\_\_\_

Number of children \_\_\_\_\_

# Conditions

Check ( ✓ ) symptoms you currently have or have had in the past year:

- AIDS
- Alcoholism
- Anemia
- Anorexia
- Appendicitis
- Arthritis
- Asthma
- Bleeding Disorders
- Breast Lump
- Bronchitis
- Bulimia
- Cancer
- Cataracts

- Chemical Dependency
- Chicken Pox
- Diabetes
- Emphysema
- Epilepsy
- Glaucoma
- Goiter
- Gonorrhea
- Gout
- Heart Disease
- Hepatitis
- Hernia
- Herpes

- High Cholesterol
- HIV Positive
- Kidney Disease
- Liver Disease
- Measles
- Migraine Headaches
- Miscarriage
- Mononucleosis
- Multiple Sclerosis
- Mumps
- Pacemaker
- Pneumonia
- Polio

- Prostate Problem
- Psychiatric Care
- Rheumatic Fever
- Scarlet Fever
- Stroke
- Suicide Attempt
- Thyroid Problems
- Tonsillitis
- Tuberculosis
- Typhoid Fever
- Ulcers
- Vaginal Infections
- Venereal Disease

# Medications

List medications you are currently taking:

# Allergies

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Pharmacy Name \_\_\_\_\_ Phone \_\_\_\_\_

# Family History

Fill in health information about your immediate family:

Relation	Age	State of Health	Age at Death	Cause of Death	Check ( ✓ ) if your blood relative had any of the following:	
					Disease:	Relationship to You:
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
Sisters					Heart Disease, Strokes	
					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

## Hospitalizations

## Pregnancies

Year	Hospital	Reason for Hospitalization and Outcome

Year of Birth	Sex of Birth	Complications If Any

Have you ever had a blood transfusion?  Yes  No  
 If yes, please give approximate dates: \_\_\_\_\_

## Health Habits

Check ( ✓ ) which you use and how much you use:

Caffeine	
Tobacco	
Street Drugs	
Other	

Serious Illness / Injuries	Date	Outcome

## Occupational

Check ( ✓ ) if your work exposes you to:

Stress		Hazardous Substances	
Heavy Lifting		Other	

Occupation: \_\_\_\_\_

To the best of my knowledge, the above information is complete and correct. I understand it is my responsibility to inform my doctor if I or my minor child ever have a change in health.

\_\_\_\_\_  
Signature of Patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Date

\_\_\_\_\_  
Please print name of Patient, Parent, Guardian, or Personal Representative

\_\_\_\_\_  
Relationship to Patient

\_\_\_\_\_  
Reviewed By

\_\_\_\_\_  
Date