



Last Name Middle Name First Name Today's Date

What is the reason for your visit today?

What symptoms are you having now?

List the Doctor who referred you and any other Doctor that you have seen in the last 12 months

Table with 4 columns: Doctor's Name, Address, City/State, Phone/Fax

Please list ALL medications that you are currently taking

Table with 3 columns: Name of Medication, Dose, Times per Day

Pharmacy Name: Phone# Location:

Allergies: (Include drugs that cause indigestion or do not agree with you) Latex Allergy: Yes No

Vaccines: 1. Pneumonia Month Year 2. Flu Month Year

Social History: Have you ever smoked cigarettes? Yes No Average # of packs per day? How many years? Year quit? Do you currently use tobacco? Yes No Do you consume alcohol? Yes No Average amount per day? Do you use recreational/street drugs? Yes No If yes, what type?

Nutrition: What is your usual weight? lbs. Has your weight changed? Gained lbs. or lost lbs., in months/years

Medical History

CURRENT/PAST MEDICAL HISTORY
(Check ALL that apply)

CONSTITUTIONAL:

- Good Health Lately
- Unusual Fatigue/Weakness

EYES:

- Glaucoma
- Wear Glasses/Contact Lenses
- Cataracts
- Blurred Vision
- Double Vision

ENT:

- Hard of Hearing or deaf
 - Ear Infections
 - Ringing in Ears
 - Chronic Sinus Problems/Runny Nose
- Changes/Difficulty in:
- Taste
 - Smell
 - Voice

GENITOURINARY:

- Kidney Disease/Stones
- Kidney Failure
- Burning or Pain on Urination
- Blood in Urine
- Men: Prostate Problem
- Women: Menstrual Irregularity or Abnormal Bleeding
- Pelvic Pain

CARDIOVASCULAR:

- Chest Pain/Angina Pectoris
- Palpitations
- Heart Murmur
- High Blood Pressure
- Heart Attack
- Congestive Heart Failure
- High Cholesterol/Triglycerides

NEUROLOGICAL:

- Brain, Spinal Cord or Nerve Problems
- Light-Headedness, Dizziness or Fainting Spells
- Convulsions, Seizures, Spasms, Epilepsy
- Stroke/TIA or Paralysis
- Head Injury
- Numbness, Tingling
- Tremors

RESPIRATORY:

- Chronic or Frequent Cough
- Bloody Sputum
- Shortness of Breath
- Asthma/Recurrent Wheezing
- Emphysema
- Pneumonia

GASTROINTESTINAL:

- Nausea
- Vomiting
- Heartburn
- Indigestion/Dyspepsia
- Stomach Fluid Refluxing Into Mouth
- Peptic Ulcers
- Hiatal Hernia
- Trouble/Pain Swallowing
- Lump or Sensation in Throat
- Food Sticking
- Upper Abdominal Pain
- Bloating
- Belching
- Lower Abdominal Pain
- Diarrhea
- Constipation
- Rectal Bleeding
- Black or Tarry Stools
- Hidden Blood in Stool
- Excessive Rectal Gas/Flatus
- Loss of Stool/Fecal Accident
- Anemia
- Chronic Aspirin Use
- Poor Appetite
- Pancreas Problems
- Hepatitis or in the Past
- Transfusion
- Jaundice or Liver Problems

**HEMATOLOGIC/LYMPHATIC/
CANCER:**

- Anemia
- Bleeding, Clotting or Bruising Tendency
- Sickle Cell Trait or Disease
- Swelling/Warmth/Tenderness of Veins/Phlebitis
- Lumps or Swollen Glands in Neck
- Leukemia
- Blood Transfusion Year: _____
- Cancer: Type: _____

Year: _____

FAMILY HISTORY OF CANCER:

Relationship: _____

Type: _____

Relationship: _____

Type: _____

Relationship: _____

Type: _____

INFECTIOUS DISEASES:

- Hepatitis
- HIV Positive
- Tuberculosis
- TB Exposure
 - Night Sweats
 - Cough
 - Fever

ENDOCRINE:

- Glandular or Hormone Problem
- Heat or Cold Intolerance
- Excessive Skin Dryness
- Excessive Thirst or Urination
- Weight Problem
- Diabetes
- Hypothyroidism/Goiter
- Hyperthyroidism

SKIN/BREAST:

- Rashes or Itching
- Change in Skin Color or Moles
- Varicose Veins
- Breast Pain/Lump
- Breast Discharge or Rash

MUSCULOSKELETAL:

- Joint Pain/Arthritis
- Weakness of Muscles or Joints
- Back Pain
- Gout
- Osteoporosis
- Neck/Back Pain

SURGERY/ANESTHESIA/SCREENING:

Last Mammogram: _____

Last PSA: _____

Last Colonoscopy: _____

- Problems with Anesthesia
- Operations
Type & Year

PSYCHIATRIC:

- Anxiety/Agitation
- Depression
- Crying for No Reason
- Insomnia
- Alcoholism
- Drug Problem (Now/Past)

Describe you mood/spirit: _____

Do you feel depressed? _____

What is your biggest worry? _____

Other issues: _____

FOR WOMEN:

How old were you when your menstrual cycle began? _____

What age at Menopause? _____

Date of last menstrual cycle? _____

Past Pregnancy? Yes _____ How many children? _____

Is there a possibility you might be pregnant? _____

Have you taken birth control pills? _____ If yes, at what age did you start _____ stop _____

Have you ever taken hormone replacement? Yes _____ No _____ How long? _____

OTHER PAST ILLNESSES:

LIVING WILL:

Do you have a Living Will? Yes _____ No _____

If no, do you want information: Yes _____ No _____

Who is your healthcare surrogate? _____