

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Date \_\_\_\_\_

**PRESENT ILLNESS**

Describe your present medical symptoms: \_\_\_\_\_

\_\_\_\_\_

List all allergies – including any drugs (what was the reaction?)

\_\_\_\_\_

\_\_\_\_\_

List your current medications (Prescription, nonprescription drugs, birth control pills, supplements and herbs)

<u>Name</u>	<u>Dosage</u>	<u>How many times/day?</u>
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\_\_\_\_\_

\_\_\_\_\_

**PAST MEDICAL HISTORY**

**(1) Surgeries**

<u>Type of Surgery</u>	<u>Date</u>	<u>Where treated?</u>
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\_\_\_\_\_

\_\_\_\_\_

**(2) Previous significant medical problems/hospitalizations**

<u>Type of Illness</u>	<u>Date</u>	<u>Where treated?</u>
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\_\_\_\_\_

\_\_\_\_\_

**Have you ever had any problems in the following areas?**

- |   |  |   |
|---|--|---|
| <input type="checkbox"/> Asthma               | <input type="checkbox"/> Hepatitis               | <input type="checkbox"/> Menstrual Problems     |
| <input type="checkbox"/> Bladder Problems     | <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Prostate Problems      |
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> HIV or AIDS             | <input type="checkbox"/> Sm. Intestine Problems |
| <input type="checkbox"/> Epilepsy or Seizures | <input type="checkbox"/> Kidney Problems         | <input type="checkbox"/> Spleen Problems        |
| <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Lg. Intestine Problems  | <input type="checkbox"/> Stomach Problems       |
| <input type="checkbox"/> Headaches            | <input type="checkbox"/> Liver Problems          | <input type="checkbox"/> Thyroid Problems       |
| <input type="checkbox"/> Heart Problems       | <input type="checkbox"/> Lung Problems           |   |

## FAMILY MEDICAL HISTORY

List any medical problems of the following blood relatives:

Father \_\_\_\_\_

Mother \_\_\_\_\_

Siblings \_\_\_\_\_

Do you have relatives with any of the following illnesses?

	Yes	No	RELATIONSHIP
Hearth Attack (age <65)	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ovarian Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sickle Cell Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

## SOCIAL HISTORY

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

Current or previous smoker? \_\_\_\_\_ How much? \_\_\_\_\_ For how many years? \_\_\_\_\_ Quit date? \_\_\_\_\_

Do you drink alcohol? \_\_\_\_\_ Drinks of wine/beer/hard liquor per day/week: \_\_\_\_\_

Do you use recreational drugs? \_\_\_\_\_ If so, what type? \_\_\_\_\_ Do you exercise regularly? \_\_\_\_\_

What is your diet?     General     Low Fat     Vegetarian

Do you have any risks for HIV exposure?

Blood transfusion     IV Drug use     Multiple sex partners     NONE

## REVIEW OF SYSTEMS

Do you have any unusual:

	Yes	No		Yes	No
Fevers?	<input type="checkbox"/>	<input type="checkbox"/>	<b>CARDIAC</b>		
Night Sweats?	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath w/ minimal activity?	<input type="checkbox"/>	<input type="checkbox"/>
Chills?	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath when lying flat?	<input type="checkbox"/>	<input type="checkbox"/>
Fatigue?	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of legs?	<input type="checkbox"/>	<input type="checkbox"/>
Have you gained or lost more than 10 pounds in 6 months?	<input type="checkbox"/>	<input type="checkbox"/>	Are you ever awakened from sleep with shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>
<b>RESPIRATORY</b>	<b>Yes</b>	<b>No</b>	<b>GASTROINTESTINAL</b>	<b>Yes</b>	<b>No</b>
Persistent Cough?	<input type="checkbox"/>	<input type="checkbox"/>	Any abdominal pain?	<input type="checkbox"/>	<input type="checkbox"/>
Sputum/Phlegm production?	<input type="checkbox"/>	<input type="checkbox"/>	Bloating/Swelling?	<input type="checkbox"/>	<input type="checkbox"/>
Shortness of breath?	<input type="checkbox"/>	<input type="checkbox"/>	Nausea?	<input type="checkbox"/>	<input type="checkbox"/>
Coughing up blood?	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting?	<input type="checkbox"/>	<input type="checkbox"/>
<b>CARDIAC</b>	<b>Yes</b>	<b>No</b>	Diarrhea?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any chest pain or discomfort?	<input type="checkbox"/>	<input type="checkbox"/>	Constipation?	<input type="checkbox"/>	<input type="checkbox"/>
Palpitations?	<input type="checkbox"/>	<input type="checkbox"/>	Blood in your stool?	<input type="checkbox"/>	<input type="checkbox"/>
			Black tarry stools?	<input type="checkbox"/>	<input type="checkbox"/>
			Have your bowel habits changed?	<input type="checkbox"/>	<input type="checkbox"/>



## MUSCULOSKELETAL PAIN INVENTORY (if applicable)

When did your symptoms appear? \_\_\_\_\_

Is the condition getting progressively worse?  Yes  No  Unknown

Where are you feeling pain, numbness, or tingling? \_\_\_\_\_

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) \_\_\_\_\_

Type of pain:  Sharp  Dull  Throbbing  Numbness  Aching  Other  
 Shooting  Burning  Tingling  Cramps  Stiffness  Swelling

How often do you have this pain? \_\_\_\_\_

Is it consistent or does it come and go? \_\_\_\_\_

Does it interfere with your:

Work  Daily Routine  
 Sleep  Recreation

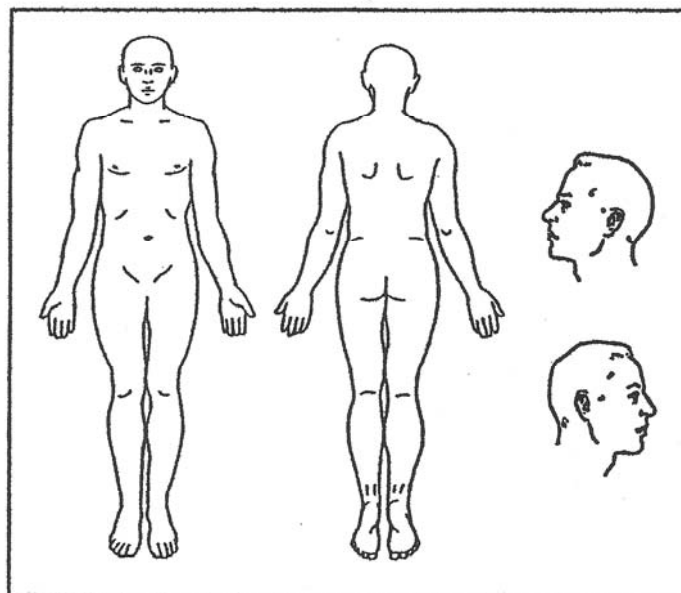
Activities or movements that are painful to perform:

Sitting  Stretching  
 Bending  Walking  
 Standing

Have you seen a doctor about it?

Yes  No Name of doctor: \_\_\_\_\_

Did you have an x-ray?  Yes  No



(Mark the origin of your pain)