

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"/>	CARDIAC		
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"/>
RESPIRATORY	Yes	No	GASTROINTESTINAL	Yes	No
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"/>
CARDIAC	Yes	No	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

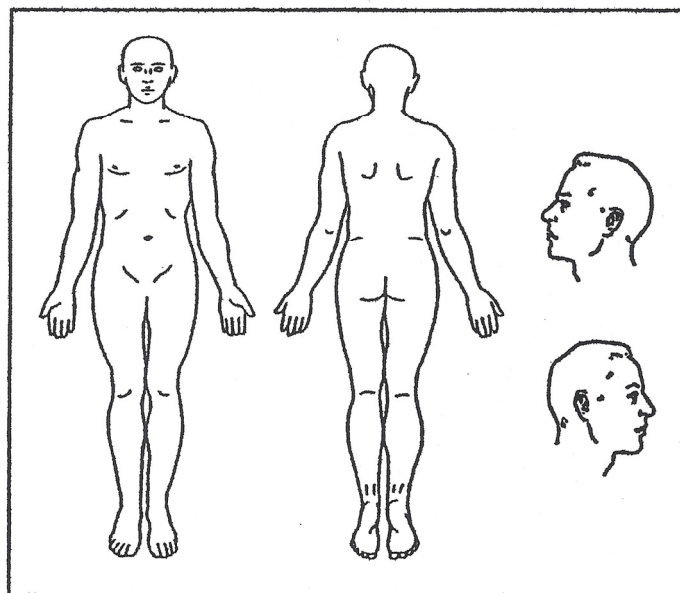
Activities or movements that are painful to perform:

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)