



Name \_\_\_\_\_ Race \_\_\_\_\_ Sex \_\_\_\_\_ Age \_\_\_\_\_

Handedness \_\_\_ L \_\_\_ R Height \_\_\_\_\_ Weight \_\_\_\_\_

Present Concerns: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Past Medical History**

**Have you ever had:**

- Chicken Pox \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Scarlet Fever \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Rheumatic Fever \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Polio \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Blood Transfusions \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_

- Hepatitis \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Tuberculosis \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Pneumonias \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Venereal Disease \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_

**Have you ever been treated for:**

- Asthma \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Emphysema \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Chronic Bronchitis \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Heart Attack \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Heart Failure \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Heart Murmur \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Abnormal Heartbeat \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- High Blood Pressure \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Colitis \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Blood Clots \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Arthritis \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Gout \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Abnormal cholesterol \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Chronic Allergies, Hay Fever \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_

- Thyroid Disease \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Diabetes \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Anemia \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Cancer \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Kidney Disease \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Kidney Stones \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Ulcer Disease \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Gall Bladder Disease \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Stroke \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Migraine \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Epilepsy (seizures) \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Psychiatric Disorder \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Glaucoma \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_
- Colon Polyps \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_

**Other problems not listed above** \_\_\_\_\_

\_\_\_\_\_

**List any operations that you have had (include approximate age):** \_\_\_\_\_

\_\_\_\_\_

**Have you ever been treated with X-Ray therapy or radioactive drugs?** \_\_\_\_\_ No \_\_\_\_\_ Yes when \_\_\_\_\_

**List any medications (and dosages) you currently are taking (include over-the-counter drugs):** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**List medication allergies:**

\_\_\_\_\_

**Social**

Single Married Widowed Divorced Occupation \_\_\_\_\_

Tobacco use? \_\_\_ No \_\_\_ Yes How many packs per day? \_\_\_\_\_  
Did you quit? \_\_\_ No \_\_\_ Yes How many years? \_\_\_\_\_  
If so, when? \_\_\_ No \_\_\_ Yes  
Alcohol? \_\_\_ No \_\_\_ Yes Amount per day? \_\_\_\_\_  
Coffee, tea, or cola? \_\_\_ No \_\_\_ Yes Amount per day? \_\_\_\_\_  
Do you exercise regularly? \_\_\_ No \_\_\_ Yes How often? \_\_\_\_\_  
Any toxic exposure? \_\_\_ No \_\_\_ Yes  
What method of contraception do you use (if applicable)? \_\_\_\_\_

**Do any of your family members have or have had:**

**Family History:**

**Age**

**Illness**

Cancer \_\_\_ No \_\_\_ Yes  
Heart attacks \_\_\_ No \_\_\_ Yes  
High blood pressure \_\_\_ No \_\_\_ Yes  
Strokes \_\_\_ No \_\_\_ Yes  
Thyroid Disease \_\_\_ No \_\_\_ Yes  
Diabetes \_\_\_ No \_\_\_ Yes  
Cholesterol \_\_\_ No \_\_\_ Yes  
Anemia \_\_\_ No \_\_\_ Yes  
Kidney disease \_\_\_ No \_\_\_ Yes  
Ulcers \_\_\_ No \_\_\_ Yes  
Other \_\_\_\_\_

Father \_\_\_\_\_  
Mother \_\_\_\_\_  
Brothers \_\_\_\_\_  
Sisters \_\_\_\_\_  
Sons \_\_\_\_\_  
Daughters \_\_\_\_\_  
Other Relatives \_\_\_\_\_

**Are you bothered with:**

Skin Rashes or Discoloration \_\_\_ No \_\_\_ Yes  
Abnormal Lumps or Glands \_\_\_ No \_\_\_ Yes  
Nausea or Vomiting \_\_\_ No \_\_\_ Yes  
Belly Pain \_\_\_ No \_\_\_ Yes  
Constipation \_\_\_ No \_\_\_ Yes  
Diarrhea \_\_\_ No \_\_\_ Yes  
Bloody or Tarry Stools \_\_\_ No \_\_\_ Yes  
Excessive or Constant Worrying \_\_\_ No \_\_\_ Yes  
Abnormal Tiredness \_\_\_ No \_\_\_ Yes  
Shortness of Breath \_\_\_ No \_\_\_ Yes  
Wheezing \_\_\_ No \_\_\_ Yes  
Chest Pain \_\_\_ No \_\_\_ Yes  
Skipped or Irregular Heartbeat \_\_\_ No \_\_\_ Yes  
Ankle Swelling \_\_\_ No \_\_\_ Yes  
Pain in Your Legs When You Walk \_\_\_ No \_\_\_ Yes  
Weakness in Your Arms or Legs \_\_\_ No \_\_\_ Yes  
Loss of Sensation (numbness) \_\_\_ No \_\_\_ Yes  
Lightheadedness \_\_\_ No \_\_\_ Yes  
Night Sweats \_\_\_ No \_\_\_ Yes  
Weight Loss \_\_\_ No \_\_\_ Yes

Loss of Consciousness (Faintings) \_\_\_ No \_\_\_ Yes  
Unusual or Serious Visual Problems \_\_\_ No \_\_\_ Yes  
Hearing Problems, Earaches \_\_\_ No \_\_\_ Yes  
Headaches \_\_\_ No \_\_\_ Yes  
Frequent Colds \_\_\_ No \_\_\_ Yes  
Hoarseness \_\_\_ No \_\_\_ Yes  
Frequent or Persistent Cough \_\_\_ No \_\_\_ Yes  
Feeling Lonely or Depressed \_\_\_ No \_\_\_ Yes  
Inability to Sleep Well \_\_\_ No \_\_\_ Yes  
Mood Swings \_\_\_ No \_\_\_ Yes  
Poor Appetite \_\_\_ No \_\_\_ Yes  
Difficulty Swallowing \_\_\_ No \_\_\_ Yes  
Hemorrhoids \_\_\_ No \_\_\_ Yes  
Trouble Urinating \_\_\_ No \_\_\_ Yes  
Arthritis \_\_\_ No \_\_\_ Yes  
Morning Stiffness \_\_\_ No \_\_\_ Yes  
Fever or Chills \_\_\_ No \_\_\_ Yes  
Impotence or Other Sexual Difficulty \_\_\_ No \_\_\_ Yes  
Bruises \_\_\_ No \_\_\_ Yes  
Weight Gain \_\_\_ No \_\_\_ Yes

Please give details of any yes answers or of other symptoms not listed above: \_\_\_\_\_

Please list any other doctors you currently see: \_\_\_\_\_

**Female Patients – Do you have any problems with:**

Cramps \_\_\_ No \_\_\_ Yes  
Irregular Periods \_\_\_ No \_\_\_ Yes  
Painful Intercourse \_\_\_ No \_\_\_ Yes

Heavy Bleeding \_\_\_ No \_\_\_ Yes  
Discharge \_\_\_ No \_\_\_ Yes  
Last Breast Exam/Mammogram \_\_\_\_\_  
Last Pap Smear \_\_\_\_\_

Your Last Menstrual Period \_\_\_\_\_

Number of Pregnancies and Any Complications \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_