Name: _____ Date of Birth: _____ Date: _____

Please list any medical problems / diseases you have:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Please list all medications, herbals and vitamins you are taking:

Name	Dose / Strength	How often do you take

Please list all allergies:

Allergic to:	Reaction

Name: _____ Date of Birth: _____ Date: _____

FAMILY HISTORY

Please list all family members including mother, father, sisters, brothers.

☐ Check here if adopted

Family Member	Name	Medical Problems/ Diagnosis	Age	Deceased
Mother				
Father				

SURGICAL HISTORY

Please list all surgeries or procedures you have had.

Date	Type of Surgical Procedure or Hospitalization	Reason for surgery or Hospitalization	Hospital	Name of Surgeon

List all other specialists you are currently seeing:

_____

_____

_____

_____

SOCIAL HISTORY

Name: _____ Date of Birth: _____
Birthplace: _____ Level of education completed: _____
What you do for work: _____

Marital Status

Current status: ☐ Divorced ☐ Married ☐ Single ☐ Widowed
Do you live alone: ☐ Yes ☐ No
Previously widowed: ☐ Yes ☐ No Previously divorced: ☐ Yes ☐ No

Children

☐ Yes ☐ No
Number of sons: _____ Number of daughters: _____

Tobacco

Are you a smoker: ☐ Yes ☐ No ☐ Former Passive smoker exposure: ☐ Yes ☐ No
Type: _____ Packs/day _____
Years smoked: _____ Year Quit: _____ Ever tried to quit: ☐ Yes ☐ No

Caffeine

Do you drink caffeine: ☐ Yes ☐ No
Type: ☐ Chocolate ☐ Coffee ☐ Soda ☐ Tablets ☐ Tea

Alcohol

Do you drink alcohol: ☐ Yes ☐ No ☐ Formerly ☐ Year Quit: _____
Type: ☐ Beer ☐ Hard Liquor ☐ Wine
Frequency: _____ Amount: _____ Last drink: _____

Lifestyle

Activity level: ☐ Sedentary ☐ Moderate ☐ Vigorous
Health club member: ☐ Now ☐ Previously ☐ Never
Type of exercise:

_____

Exercise Frequency: _____ Hours/week: _____
Hobbies/Activities:

_____

Specific type of diet: ☐ Low fat ☐ Low carb ☐ Diabetic ☐ Weight watchers
Animals in the home ☐ Yes ☐ No Type: _____
Are you the one who cleans up after the animal: ☐ Yes ☐ No

Recent Travel

Any recent travel out of the state ☐ Yes ☐ No Where: _____
Any recent travel out of the country ☐ Yes ☐ No Where: _____

Safety

Are there smoke detectors in the home? ☐ Yes ☐ No
Are there carbon monoxide detectors in the home? ☐ Yes ☐ No
Is there radon in the home? ☐ Yes ☐ No
Do you have firearms in the home? ☐ Yes ☐ No
Do you wear a seatbelt? ☐ Yes ☐ No

Advanced Directives in Place

Mark the advanced directives that you currently have in place:
☐ None ☐ DNR ☐ Living Will ☐ Durable Power of Attorney ☐ HC Proxy
Do you agree to a transfusion? ☐ Yes ☐ No

HEALTH MAINTENANCE

Please fill in the date of your most recent health maintenance event (if applicable):

Event	Date of Last
Colonoscopy/ GI procedure	
Stress test/ Cardiac procedure	
Echocardiogram	
Eye exam	
Skin exam	
Mammogram/ Breast exam	
Pap-smear	
PSA/ Prostate exam	
Rectal exam/ Stool cards/ FOBT	
Bone Density	

Vaccine/Immunization	Date of Last
Tetanus (Td)	
Pneumonia vaccine	
Flu vaccine	
Hepatitis A vaccine	
Hepatitis B vaccine	
TB/ PPD (Tuberculosis screening)	
MMR (Measles, Mumps & Rubella)	
Zostavax	

Infectious Disease History

Do you have any history of blood/ blood product transfusion? If so, when and for what reason?

Do you have any history of tick bites, Lyme disease or Rocky Mountain Spotted Fever? If so, please explain:

Have you ever had a positive PPD test (Tuberculosis screening)? If so, what happened as a result of that positive test?

Any concern for possible HIV infection? If so, please explain:

REVIEW OF SYSTEMS

Have you experienced any of the following symptoms in the past month?

CONSTITUTIONAL

Activity change	No	Yes
Chills	No	Yes
Decreased appetite	No	Yes
Fatigue	No	Yes
Fever	No	Yes
Insomnia	No	Yes
Irritability	No	Yes
Malaise/ feeling unwell	No	Yes
Night sweats	No	Yes
Abnormal paleness	No	Yes
Weakness	No	Yes
Weight gain	No	Yes
Weight loss	No	Yes

HEENT

Headache	No	Yes
Eye burning	No	Yes
Double vision	No	Yes
Eye discharge/ drainage	No	Yes
Eye dryness	No	Yes
Foreign body sensation	No	Yes
Eye itching	No	Yes
Rapid eye movements	No	Yes
Eye pain	No	Yes
Sensitivity to light	No	Yes
Eye redness	No	Yes
Visual halloes or blind spots	No	Yes
Spots/ floaters	No	Yes
Tearing	No	Yes
Glasses	No	Yes
Contacts	No	Yes
Visual Loss	No	Yes

HEENT continued...

Radical keratotomy	No	Yes
Lasik	No	Yes
Last eye exam		
Ear discharge	No	Yes
Cerumen/ ear wax	No	Yes
Ear fullness	No	Yes
Hearing loss	No	Yes
Noise exposure	No	Yes
Ear pain	No	Yes
Tinnitus/ ringing in the ears	No	Yes
Vertigo/ dizziness	No	Yes

NOSE AND SINUS

Decreased smell	No	Yes
Nasal discharge/ drainage	No	Yes
Nose bleeds	No	Yes
Facial pain	No	Yes
Infections	No	Yes
Nasal congestion	No	Yes
Sneezing	No	Yes

THROAT AND MOUTH

Taste change	No	Yes
Voice change	No	Yes
Cold sores	No	Yes
Difficulty swallowing	No	Yes
Hoarseness	No	Yes
Lump sensation	No	Yes
Pain when swallowing	No	Yes
Post nasal drip	No	Yes
Sore tongue/ tongue lesions	No	Yes
Sore throat	No	Yes
Tooth pain/ dentures/ plates	No	Yes

RESPIRATORY/ THORAX

Rapid breathing	No	Yes
Cough	No	Yes
Chest pain	No	Yes
Frequent respiratory infections	No	Yes
Coughing up blood	No	Yes
Known TB exposure	No	Yes
Positive PPD/ TB test	No	Yes
Pain with breathing "stitch"	No	Yes
Shortness of breath	No	Yes
Wheezing	No	Yes

CARDIOVASCULAR

Chest pain	No	Yes
Shortness of breath at rest	No	Yes
Shortness of breath on exertion	No	Yes
Sleep sitting up to breathe	No	Yes
Shortness of breath at night- causes awakening	No	Yes
Swelling of hands and legs	No	Yes
Nighttime urination	No	Yes
Palpitations/ rapid heart beat	No	Yes
Passing out	No	Yes

VASCULAR

Cramping in legs when walking	No	Yes
Blueing of the hands/ feet	No	Yes
Flushing or redness of hands/ feet	No	Yes
Cool extremities	No	Yes
Swelling of hands, feet or legs	No	Yes
Pain in extremities	No	Yes
Ulcers in legs, feet and arms	No	Yes
Varicose veins	No	Yes
Blood clots	No	Yes

GASTROINTESTINAL

Abdominal mass/ growth	No	Yes
Abdominal pain	No	Yes
Altered bowel habits- change from normal	No	Yes
Not eating or poor appetite	No	Yes
Black, tarry stools	No	Yes
Bloating and feeling of fullness	No	Yes
Blood in stool	No	Yes
Constipation	No	Yes
Diarrhea	No	Yes
Difficult or painful swallowing	No	Yes
Flatulence/ gas	No	Yes
Jaundice/ yellow/ history of hepatitis	No	Yes
Indigestion/ heartburn	No	Yes
Throwing up blood	No	Yes
Nausea	No	Yes
Weight loss	No	Yes
Hemorrhoids	No	Yes
Rectal bleeding	No	Yes
Reflux	No	Yes
Vomiting	No	Yes

GENITOURINARY

Back pain/ flank/ side pain	No	Yes
Change in urine color/ cloudy urine	No	Yes
Urgency to urinate	No	Yes
Decreased stream or low urine output	No	Yes
Pain when urinating	No	Yes
Foul urine odor	No	Yes
Urinating frequently	No	Yes
Mass in groin	No	Yes
Blood in urine	No	Yes
Hesitancy or difficulty urinating	No	Yes
Urine leakage/ incontinence	No	Yes

History of passing a kidney stone	No	Yes
Urgency to urinate	No	Yes

FEMALE/ WOMEN TO COMPLETE

Age of first period		
Last menstrual period		
Frequency of menstrual cycles		
Are you post-menopausal?	No	Yes
Are you on hormones?	No	Yes
Have you previously used hormones?	No	Yes
Have you ever used birth control?	No	Yes
Have you ever had an abnormal pap?	No	Yes
Do you do self breast exams?	No	Yes
Lack of libido	No	Yes
Nipple discharge	No	Yes
Breast lumps	No	Yes
Pain with sexual intercourse	No	Yes
History of uterine fibroids	No	Yes
Problems with infertility	No	Yes
Ovarian cysts	No	Yes
Sexual dysfunction	No	Yes
Vaginal itching	No	Yes
Vaginal discharge	No	Yes

MALE/ MEN TO COMPLETE

Are you circumcised?	No	Yes
erectile pain	No	Yes
Penile discharge	No	Yes
Blood in your stream	No	Yes
Scrotum/ testicular pain	No	Yes
Scrotum/ testicular mass	No	Yes
Hydrocele/ fluid around testes	No	Yes
History of Herpes Genitalia	No	Yes
Problems with fertility	No	Yes
Have you ever been treated for a sexually transmitted disease?	No	Yes
Describe your sexual function		
Normal		
Decreased		

METABOLIC/ ENDOCRINE

Voice changes	No	Yes
Cold intolerance/ feeling cold	No	Yes
Heat intolerance/ feeling hot	No	Yes
Hair loss	No	Yes
Coarse hair	No	Yes
Abnormal glucose/blood sugar tests	No	Yes
Abnormal fat distribution	No	Yes
Abnormal hair distribution	No	Yes
Chronically overweight	No	Yes
Chronically underweight	No	Yes
Clitoral enlargement	No	Yes
Darkening of skin	No	Yes
History of gout	No	Yes
Excessive perspiration	No	Yes
Excessive hunger	No	Yes
Excessive thirst	No	Yes
Generalized weakness	No	Yes
Gestational diabetes	No	Yes
Goiter	No	Yes
Gynecomastia/ male breast enlargement	No	Yes
Low sugar reactions	No	Yes
Increase in size of feet/ hands	No	Yes

NEURO/ PSYCHIATRIC

Language disorder/ Difficulty talking	No	Yes
Unclear pronunciation	No	Yes
Focal weakness	No	Yes
Difficulty walking	No	Yes
Headaches	No	Yes
Incontinence	No	Yes
In-coordination	No	Yes
Lightheadedness/ dizziness	No	Yes
Loss of consciousness/ fainting	No	Yes
Memory loss	No	Yes
Tingling/ numbness	No	Yes
Seizures	No	Yes
Speech changes	No	Yes
Tremors	No	Yes
Vertigo/ Hx of Meniere's	No	Yes
Visual changes	No	Yes
Lack of concentration	No	Yes
Do you have any anxiety?	No	Yes
Do you feel fearful?	No	Yes
Do you feel excessively happy?	No	Yes
Do you feel paranoid?	No	Yes

DERMATOLOGIC

Acne	No	Yes
Contact allergies	No	Yes
Hx of excessive sun exposure	No	Yes
Frequent skin infections	No	Yes
Hair loss	No	Yes
Women: facial hair	No	Yes
Nail changes (brittle)	No	Yes
Change in skin color	No	Yes
Severe itching	No	Yes
Excessive sweating	No	Yes
Sensitivity to light	No	Yes
Rash	No	Yes
Skin lesions: tags, moles, freckles, birthmarks	No	Yes

MUSCULOSKELETAL

Back pain- neck, mid, low back	No	Yes
Bone/ joint swelling or pain	No	Yes
Hands/ wrist/ elbow shoulder/ hips/ feet/ ankle swelling or pain	No	Yes
Muscle pain/ weakness	No	Yes

HEMATOLOGIC

Easy bruising	No	Yes
Easy bleeding	No	Yes
History of blood clots	No	Yes
Anemia or low blood count	No	Yes
Swollen lymph nodes	No	Yes

IMMUNOLOGIC

Asthma	No	Yes
Hay fever	No	Yes
Hives	No	Yes
Anaphylaxis	No	Yes
Contact dermatitis/ rashes/ metal allergy	No	Yes
Food allergies	No	Yes
"Bee" sting allergy	No	Yes
If yes, reaction type:		
Environmental allergies: pollen, pollution	No	Yes
Animals at home	No	Yes
Animals in the work place	No	Yes
Chemicals in the home	No	Yes
If yes, type:		
Chemicals in the work place	No	Yes
If yes, type:		