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Patient Name ______________________ Gender: ☐ Male ☐ Female Today's Date ______________

Age ________ Birth date ______________ Previous Physician:____________ Date of Last Physical:__________

What is your reason for visit? ____

How did you hear about us?

– Symptoms –

Check (☑) symptoms you currently have or have had in the last year.

GENERAL
- ☐ Abnormal x-ray
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Fluid retention
- ☐ Forgetfulness
- ☐ Headache
- ☐ High blood sugar
- ☐ Insomnia/sleep prob.
- ☐ Irritable
- ☐ Loss of weight
- ☐ Low blood sugar
- ☐ Nervousness
- ☐ Numbness
- ☐ Shortness of breath
- ☐ Weakness

GENITO-URINARY
- ☐ Blood in urine
- ☐ Difficulty urinating
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination
- ☐ Urine infections

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

GASTROINTESTINAL
- ☐ Bloating
- ☐ Bloody stool
- ☐ Change in bowel habits
- ☐ Constipation
- ☐ Decreased appetite
- ☐ Diarrhea
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Gall bladder trouble
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion/heartburn
- ☐ Jaundice
- ☐ Nausea
- ☐ Rectal bleeding
- ☐ Stomach pain
- ☐ Vomiting
- ☐ Vomiting blood

CARDIOVASCULAR
- ☐ Abnormal EKG
- ☐ Chest pain/angina
- ☐ Enlarged heart
- ☐ High blood pressure
- ☐ Irregular heart beat
- ☐ Low blood pressure
- ☐ Poor circulation
- ☐ Rapid heart beat
- ☐ Swelling of ankles
- ☐ Varicose veins

EYE, EAR, NOSE & THROAT
- ☐ Bleeding gums
- ☐ Blurred vision
- ☐ Crossed eyes
- ☐ Difficulty swallowing
- ☐ Double vision
- ☐ Ear pain
- ☐ Ear discharge
- ☐ Eye pain
- ☐ Frequent ear infections
- ☐ Frequent sore throat
- ☐ Hay fever/allergies
- ☐ Hoarseness
- ☐ Loss of hearing
- ☐ Nosebleeds
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Stuffy nose
- ☐ Visual flashes or halo

RESPIRATORY
- ☐ Coughing up blood
- ☐ Persistent cough
- ☐ Pleurisy
- ☐ Wheezing

SKIN
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in moles
- ☐ Rash
- ☐ Scars
- ☐ Sores that won't heal

MEN only
- ☐ Breast lump
- ☐ Erection difficulties
- ☐ Lump in testicles
- ☐ Penis discharge
- ☐ Sore on penis
- ☐ Other

WOMEN only
- ☐ Abnormal pap smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme menstrual pain
- ☐ Heavy periods
- ☐ Hot flashes
- ☐ Nipple discharge
- ☐ Painful intercourse
- ☐ Vaginal discharge
- ☐ Other

Date of last menstrual period: __________

Period every _______ days

Are you pregnant? __________

Birth control method: ______________

Number of children: ________

Number of miscarriages: ____

Date of last Pap Smear: ______________

☐ Normal ☐ Abnormal

Date of last mammogram: ____________

☐ Normal ☐ Abnormal

– Conditions –

Check (☑) conditions you currently have or have had in the past.

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Blood clots
- ☐ Breast lump
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical dependency
- ☐ Chicken pox
- ☐ Colitis
- ☐ Depression
- ☐ Diabetes
- ☐ Emphysema/COPD
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart attack
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Infertility
- ☐ Kawasaki's disease
- ☐ Kidney disease
- ☐ Kidney stone
- ☐ Liver Disease
- ☐ Measles
- ☐ Migraine headache
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Murmur
- ☐ Osteoporosis
- ☐ Pacemaker
- ☐ Phlebitis
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate problem
- ☐ Psychiatric care
- ☐ Rheumatic fever
- ☐ Seizure
- ☐ Sexually transmitted disease "STD"
- ☐ Stroke
- ☐ Suicide attempt
- ☐ Thyroid problems
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other

– Medications – Current prescription and over-the-counter medications

____

____

____

____

Pharmacy Name: ________________ Phone: __________

– Allergies –

____

____

____

____

____

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– Past History – Give names and dates

Previous Surgery	
Previous Hospitalizations, Major Illnesses or Injuries	

– Family History –

	Age if living	Age at death	Medical conditions or cause of death
Father			
Mother			
Brothers Number ______			
Sisters Number ______			
Children Number ______			
Number living in household:			

Check if any relatives have had:	Relationship to you:
☐ Arthritis/Gout	
☐ Asthma/Hay Fever	
☐ Cancer	
☐ Chemical Dependency	
☐ Diabetes	
☐ Heart Disease/Heart Attack	
☐ High Blood Pressure	
☐ High Cholesterol	
☐ Kidney Disease	
☐ Mental Illness/Suicide	
☐ Thyroid Trouble	
☐ Tuberculosis	
☐ Stroke	
☐ Other	

– Personal –

Marital Status: ☐ Married ☐ Divorced ☐ Single ☐ Widowed

Sexual Preference: ☐ Male ☐ Female ☐ Both

Any history of sexual abuse? ☐ Yes ☐ No

Physical abuse? ☐ Yes ☐ No

Work

Occupation: ______

Company: ______

Does your work expose you to: ☐ Stress ☐ Noise ☐ Heavy Lifting ☐ Hazardous Materials ☐ Other

Smoking

Packs per day: ______

Number years: ______

Year quit: ______

Type: ☐ Cigarette ☐ Pipe ☐ Cigar ☐ Chew

Do you have an interest in quitting? ☐ Yes ☐ No

Coffee – cups per day: ______

Aspirin – pills per day: ______

Street drugs used: ______

Have you ever used injection drugs? ☐ Yes ☐ No

Have you ever had a blood transfusion? ☐ Yes ☐ No

If so, please give date: ______

Exercise

Amount: ☐ Sedentary ☐ Mild ☐ Moderate ☐ Heavy

Describe Activities: ______

Weight gain in last year? ☐ Yes ☐ No

Weight loss in last year? ☐ Yes ☐ No

Amount: ______

Alcohol

Usage: ☐ Never ☐ Moderate ☐ Rare ☐ Heavy

Alcohol Problem? ☐ Yes ☐ No

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change of health.

______ Signature of patient, parent or guardian ______ Date

______ Printed name of patient, parent or guardian ______ Relationship to patient

______ Reviewed by (Physician) ______ Date