

Name _____

Date of Birth _____

PAST MEDICAL HISTORY

Please check any of the following conditions you are currently being, or have been, treated for.

- | | | | |
|--|--|---|--|
| <input type="checkbox"/> Heart problems | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Eye disorder | <input type="checkbox"/> High/Low blood pressure |
| <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Seizures | <input type="checkbox"/> HIV | <input type="checkbox"/> Kidney/Bladder problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Lung problems | <input type="checkbox"/> Stroke | <input type="checkbox"/> Liver problems/Hepatitis |
| <input type="checkbox"/> Psychiatric care | <input type="checkbox"/> Headaches | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Heartburn/Reflux | <input type="checkbox"/> Environmental allergies | <input type="checkbox"/> Cancer | <input type="checkbox"/> Neurological problems |
| <input type="checkbox"/> Anemia/Blood problems | <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Ulcers/Colitis | <input type="checkbox"/> Sinus/Ear/Throat problems |

Please describe any current or past medical problems not listed above.

Please list your other healthcare providers (specialists, dentist, eye doctor, chiropractor, etc).

Please list your surgeries and overnight hospitalizations.

Please list allergies to medication/food/latex.

Please list your medications and doses including over-the-counter medicine and vitamins/supplements.

FAMILY HISTORY

	<u>Living</u>	<u>Age (or age at death)</u>	<u>List any serious illnesses</u>
Mother	Yes No	_____	_____
Father	Yes No	_____	_____
Siblings	Yes No	_____	_____
	Yes No	_____	_____
Children	Yes No	_____	_____
	Yes No	_____	_____

Has a family member (parents/siblings/children/grandparents/aunts/uncles) had any of the following?

- | | |
|----------------------------|-----------------------------|
| Anemia/Blood disease _____ | Cancer _____ |
| Diabetes _____ | Glaucoma _____ |
| Heart disease _____ | High blood pressure _____ |
| HIV/AIDS _____ | Mental Illness _____ |
| Stroke _____ | Other serious illness _____ |

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VACCINES RECEIVED (give approximate date of most recent)

Tetanus _____ Pneumonia _____ Shingles _____
Flu _____ Hepatitis B _____ HPV _____

CANCER AND OTHER SCREENINGS (give result and approximate date of most recent)

Dental exam _____ Eye exam _____
Bone Density test _____ Colonoscopy _____
PAP smear _____ Mammogram _____
Prostate exam/PSA _____ PPD (TB skin test) _____
HIV test _____ Hepatitis test _____

SAFETY/PREVENTIVE SCREENING QUESTIONS

Do you have any problems with falling or doing routine tasks at home? _____

Do you feel safe at home? _____

Are conflicts in your family or relationship sometimes handled by pushing, hitting, or cruelty? _____

Do you have guns in your home? _____ If yes, are they stored securely? _____

Do you have working smoke alarms? _____

Do you wear your seat belt? _____ Do you wear your bike helmet? _____

Do you have a living will and/or healthcare power of attorney? _____

Occupation: _____ Highest level of school completed: _____

Tobacco use: previous never current _____ pack per day, year started _____, year quit _____

Alcohol use: previous never current _____ drinks per day/week

Caffeine use: coffee tea soda/pop _____ drinks per day

Drug use: previous never current _____

Sexual Partners: _____ in the past year, _____ in your lifetime. male/female/both

Have you ever had a sexually transmitted infection or disease "STD"? _____

Which of the following are included in your diet:

Grains and starches a lot some few
Fruits and Vegetables a lot some few
Dairy foods a lot some few
Meats a lot some few
Sweets a lot some few

Exercise activities: _____

Exertion level: minimal moderate heavy _____ days per week for _____ minutes

FEMALES ONLY

Periods occur every _____ days, lasting for _____ days, with most recent period started ____-____-____

Age periods started _____, age periods stopped _____

Number of pregnancies _____, deliveries _____, miscarriages _____, abortions _____, c-sections _____

What method of birth control are you using? _____

Have you had any abnormal PAP smears? _____

Signature _____

Date _____

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REVIEW OF SYSTEMS - Please CIRCLE and describe any symptoms you are CURRENTLY having

<p><u>METABOLIC/ENDOCRINE</u> Weight change _____ Warmer/Colder than others _____ Increased sweating _____ Increased thirst or urination _____ Fatigue _____ Skin/Hair/Nail changes _____</p> <p><u>EYES, EARS, NOSE, THROAT</u> Eye pain _____ Abnormal vision _____ Hearing problem _____ Ear pain _____ Dizziness/Vertigo _____ Nasal drainage _____ Sore mouth/throat _____</p> <p><u>CARDIOVASCULAR</u> Chest pain _____ Fast/Irregular heart beat _____ Ankle swelling _____ Calf pain with walking _____ Fainting _____</p> <p><u>RESPIRATORY</u> Short of breath _____ Wheezing _____ Cough up blood _____</p> <p><u>MUSCULOSKELETAL</u> Neck/Back pain _____ Joint pain _____ Muscle pain _____</p> <p><u>BLOOD/LYMPHATIC</u> Bleeding/Bruising easily _____ Enlarged glands _____ Fever _____</p> <p><u>ALLERGIC/IMMUNOLOGIC</u> Seasonal/Environmental allergies _____ Rashes/Hives _____</p>	<p><u>SKIN/BREAST</u> Breast lump _____ New/Changing mole/spot _____</p> <p><u>NEUROLOGIC</u> Muscle weakness/paralysis _____ Tremor/Shakes _____ Numbness/Tingling _____ Inability to talk _____ Convulsions/Seizures _____ Difficulty falling/staying asleep _____ Memory problems _____ Severe headaches _____</p> <p><u>GASTROINTESTINAL</u> Heartburn _____ Nausea/Vomiting _____ Trouble swallowing _____ Abdominal pain _____ Blood in stools or black stools _____ Constipation _____ Diarrhea _____ Belching/Gas _____ Hemorrhoids _____</p> <p><u>PSYCHIATRIC</u> Feeling down, depressed, or hopeless _____ Feeling stressed _____ Have little interest or pleasure in doing things _____ Thoughts of suicide _____</p> <p><u>GENITO-URINARY</u> Blood in urine _____ Frequent urination _____ Pain/Burning with urination _____ Waking to urinate _____ Bladder leakage _____ Change in urinary stream _____ Lack of interest in or enjoyment of intercourse _____ Erection problems _____ Testicular/Scrotal lumps _____ Irregular vaginal bleeding _____ Pain with periods or intercourse _____</p>
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