Name _____ Date of Birth _____

PAST MEDICAL HISTORY

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

□Heart problems	□Shortness of breath	□Eye disorder	□High/Low blood pressure
□High cholesterol	□Seizures	□HIV	□Kidney/Bladder problems
□Diabetes	□Lung problems	□Stroke	□Liver problems/Hepatitis
□Psychiatric care	□Headaches	□Arthritis	□Thyroid problems
□Heartburn/Reflux	□Environmental allergies	□Cancer	□Neurological problems
□Anemia/Blood problems	□Depression/Anxiety	□Ulcers/Colitis	□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 HSITORY

	Living		Age (or age at death)	List any serious illnesses
Mother	Yes	No	_____	_____
Father	Yes	No	_____	_____
Siblings	Yes	No	_____	_____
	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 _____

Name _____ Date of Birth _____

VACCINES RECEIVED (give approx date of most recent)

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

CANCER AND OTHER SCREENINGS (give result and approx 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 _____

Name _____ Date of Birth _____

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

METABOLIC/ENDOCRINE
Weight change _____
Warmer/Colder than others _____
Increased sweating _____
Increased thirst or urination _____
Fatigue _____
Skin/Hair/Nail changes _____

EYES, EARS, NOSE, THROAT
Eye pain _____
Abnormal vision _____
Hearing problem _____
Ear pain _____
Dizziness/Vertigo _____
Nasal drainage _____
Sore mouth/throat _____

CARDIOVASCULAR
Chest pain _____
Fast/Irregular heart beat _____
Ankle swelling _____
Calf pain with walking _____
Fainting _____

RESPIRATORY
Short of breath _____
Wheezing _____
Cough up blood _____

MUSCULOSKELETAL
Neck/Back pain _____
Joint pain _____
Muscle pain _____

BLOOD/LYMPHATIC
Bleeding/Bruising easily _____
Enlarged glands _____
Fever _____

ALLERGIC/IMMUNOLOGIC
Seasonal/Environmental allergies _____
Rashes/Hives _____

SKIN/BREAST
Breast lump _____
New/Changing mole/spot _____

NEUROLOGIC
Muscle weakness/paralysis _____
Tremor/Shakes _____
Numbness/Tingling _____
Inability to talk _____
Convulsions/Seizures _____
Difficulty falling/staying asleep _____
Memory problems _____
Severe headaches _____

GASTROINTESTINAL
Heartburn _____
Nausea/Vomiting _____
Trouble swallowing _____
Abdominal pain _____
Blood in stools or black stools _____
Constipation _____
Diarrhea _____
Belching/Gas _____
Hemorrhoids _____

PSYCHIATRIC
Feeling down, depressed, or hopeless _____
Feeling stressed _____
Have little interest or pleasure in doing things _____
Thoughts of suicide _____

GENITO-URINARY
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 _____