

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 any your other healthcare providers (dentist, eye doctor, physicians, chiropractor, etc).

Please list your surgeries and overnight hospitalizations.

Please list any medication/food/latex allergies.

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

Preferred Pharmacy (name and location):

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	_____	_____
	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 _____ |
| High cholesterol _____ | 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? _____

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? _____

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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 _____