This form is very important to you and your doctor. Please spend adequate time filling it our correctly and completely.

Today's Date: _____

Personal Information

Name (First, Initial, Last) _____ Phone Number _____

Address _____ City _____ State _____ Zip _____

Status ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Other Occupation _____

Date of Birth _____ Age _____ Sex_____ Social Security Number _____

Emergency Contact (Relation & Phone Number) _____

Medications (Name, Dose) _____

_____

_____

Allergies to medications (No, Yes - list) _____

Surgeries (Type of surgery and when) _____

_____

Medical History (List all hospitalizations and/or chronic medical conditions for which you've seen a doctor) _____

_____

_____

Social History

Have you/do you use illicit drugs? If so, which ones? _____

Do you drink alcoholic beverages? If so, how many and how often? _____

Have you ever chewed, smoked or used tobacco? If so, how much a day and for how long? _____

Your Family History (any diseases or illnesses in children, parents or grandparents)

( ) Significant family history - list below ( ) No significant family history ( ) Adopted

Name of Family Member	Age	Health Problem(s)	Cause & Age of Death
Father:			
Mother:			
Siblings:			
Spouse:			
Children:			

These are questions about your general health. Please check all boxes that apply now or in the past. If not currently experiencing, write "PAST" next to the problem. This sheet is confidential and private between you and your doctor.

Habits

- [ ] Smoke cigarettes
- [ ] More than 2 alcoholic drinks daily
- [ ] Weight gain/loss >15 lbs in past year
- [ ] Used recreational drugs past 5 years
- [ ] Don't exercise regularly

Safety

- [ ] Home not made childproof
- [ ] No smoke detectors in your home

Nutrition

- [ ] Like salt and salty foods
- [ ] Regularly eat fast food/cakes/cookies
- [ ] Not many vegetables/fiber foods

Blood & Lymphatic

- [ ] Frequent infections
- [ ] Have you had a blood transfusion
- [ ] Have anemia
- [ ] Lumps in neck, armpits or groin

Skin, Nails & Hair

- [ ] Hair loss
- [ ] Nail change
- [ ] Excessive itching
- [ ] Dry skin
- [ ] Rash
- [ ] Abnormal sore/mole/growth
- [ ] Changing moles (color/shape)
- [ ] Unwanted birth marks
- [ ] Unusual or excessive hair growth

Breasts

- [ ] Nipple discharge/bleeding
- [ ] Skin dimpling
- [ ] Pain
- [ ] Change in size/color
- [ ] Lumps

Sexuality

- [ ] Have birth control needs
- [ ] Want to discuss sexual concerns
- [ ] Worried about past sexuality/HIV

Head

- [ ] Have you had head trauma
- [ ] Severe headaches
- [ ] Sinusitis or allergies
- [ ] Visual loss
- [ ] Double vision
- [ ] Hearing loss
- [ ] Voice hoarseness
- [ ] Ringing in ears
- [ ] Spinning
- [ ] Bloody noses
- [ ] Lip/gum/mouth sores

Neck

- [ ] Stiffness
- [ ] Masses

Lungs

- [ ] Get excessively sleepy while driving
- [ ] Early morning headaches
- [ ] Blood clots
- [ ] Asthma
- [ ] Snore loudly at night
- [ ] Emphysema
- [ ] Tuberculosis or exposure to TB
- [ ] Coughing up blood
- [ ] Shortness of breath
- [ ] Pain with breathing

Cardiovascular

- [ ] Wake up at night short of breath
- [ ] High cholesterol
- [ ] Rheumatic fever
- [ ] Heart attack
- [ ] Chest pressure, pain or tightness
- [ ] Arrhythmia
- [ ] Shortness of breath on exertion
- [ ] Can not sleep flat
- [ ] Urinate > once after bedtime
- [ ] Ankle swelling
- [ ] High blood pressure
- [ ] Do your feet get cold easily
- [ ] Phlebitis

Neurological

- [ ] Loss of consciousness
- [ ] Memory loss/forgetfulness/confusion
- [ ] Stroke
- [ ] Numbness/Tingling (where) _____
- [ ] Dizziness

Prevention (what year was your last)

Pap smear _____
Breast exam _____
Mammogram _____
Digital rectal exam _____
Sigmoidoscopy _____
Colonoscopy _____
TB skin test _____
Tetanus immunization _____
Flu shot _____
Pneumonia immunization _____
PSA prostate blood _____
Cholesterol blood test _____
Dental exam _____
Vision exam _____
Hearing test _____

Gastrointestinal

- [ ] Loss of appetite
- [ ] Difficulty swallowing
- [ ] Acid reflux
- [ ] Heartburn or indigestion
- [ ] Food intolerance
- [ ] Nausea or vomiting
- [ ] Ulcers
- [ ] Abdominal pain
- [ ] Hepatitis/liver disease/jaundice
- [ ] Gallbladder disease
- [ ] Pancreatitis
- [ ] Constipation
- [ ] Diarrhea
- [ ] Blood in stool
- [ ] Black stools/black tarry streaks
- [ ] Rectal pain
- [ ] Hemorrhoids
- [ ] Stool incontinence

Genitourinary

- [ ] Kidney stones
- [ ] Burning with urination
- [ ] Urinary frequency/urgency
- [ ] Blood in urine
- [ ] Difficulty starting to urinate
- [ ] Infertility
- [ ] Urine incontinence/leaking

Psychiatric

- [ ] Mood problems
- [ ] Anxiety
- [ ] Concentration problems
- [ ] Suicidal thoughts/plans
- [ ] Needing counseling

Male

- [ ] Impotence/ejaculatory problems
- [ ] Scrotal/testicle mass or enlargement
- [ ] Hernia
- [ ] Prostate problems
- [ ] Weak urine stream
- [ ] Penile lesion/discharge/STDs

Females

- [ ] Bleeding after intercourse
- [ ] Abnormal periods
- [ ] Sores/lesions/STDs
- [ ] Vaginal discharge/itching
- [ ] Pain with intercourse
- [ ] Abnormal pap smears
- [ ] Hot flashes