



PATIENT'S NAME: _____

D.O.B. _____

SELF PAST MEDICAL HISTORY:

(Check no or yes to any problem you have ever been treated for and indicate the year of treatment.)

Disease	no	yes	year	Disease	no	yes	year	Disease	no	yes	year
Arthritis				High Cholesterol				Venereal Disease			
Rheumatoid Arthritis				Peripheral Vascular Disease				HIV/AIDS			
Lupus				Stroke				Asthma			
Osteoporosis				Blood Clots				Emphysema			
Broken bones				Bleeding problems				Cancer			
Ruptured Disc				Varicose Veins				Hereditary Defects			
Sciatica				Kidney Disease				Cataracts			
Deaf/hearing loss				Bladder Infection				Glaucoma			
Diabetes				Sickle Cell Anemia				Depression			
Stomach ulcers				Blood Transfusion				Alcohol / Drug Abuse			
Hypertension				Hepatitis				Head injury			
Heart Attack				Cirrhosis				Seizures			
Heart Failure				Gall stones				Fainting spells			
Heart Murmur				Anemia				Insomnia			
Polio				Tuberculosis				Gout			

SURGICAL/HOSPITALIZATION HISTORY:

PRIOR SURGERIES:

Type of Surgery

Date Of Surgery

PRIOR NON-SURGICAL HOSPITALIZATIONS, MAJOR ILLNESSES OR INJURIES:

Reason for Admit

Date of Admit



PATIENT'S NAME: _____

D.O.B. _____

SOCIAL HISTORY: (please circle all that apply)

Occupation: _____ Marital status: S M W DV SP
 Are you working now? retired yes no If no, when did you last work? _____
 Place of birth: _____
 Grade of school completed: 7 8 9 10 11 12 GED Technical College Bachelors Masters
 I live in a: house apartment condominium mobile home boat
 My home is: single-level Multi-level _____ # of stairs to enter: _____ # of stairs to inside
 I live: alone w/Spouse w/Parents w/ Children other: _____
 What % of the time spend wearing seat belts? _____ %
 Do you have smoke detectors where you live? no yes
 Do you have guns where you live? no yes If yes, are they kept in a gun safe? no yes
 Are sexually active? no yes If yes I am active with: men women both
 Do you practice safe sex? n/a no yes
 Have you had a new partner since last exam? no yes

Females: Last Menstrual Period: _____ Periods - Regular Irregular Pain / Cramps
 Days of flow: _____ Length of flow: _____ Do monthly Self breast exam? no yes
 Number of pregnancies: 0 1 2 3 4 5 6 7 Pain or bleeding during sex? no yes
 Live births: 0 1 2 3 4 5 6 7 Birth Control Methods: _____
 Number of miscarriages: 0 1 2 3 4 5 6 7 B.C. Pill (name) _____
 Number of abortions: 0 1 2 3 4 5 6 7

Males: Do you check your testicles monthly? no yes
 History of undescended testicle, testicle mass, or testicle lump? no yes
 Having any sexual difficulty? no yes

Alcohol Consumption: Never
 Type: Beer Wine Whiskey
 Frequency: Daily Weekly Monthly Social
 Amount: 1 2 3 4 5 6 7 8 9
 Quit, when:

Caffeine Consumption: None
 Type: Chocolate Coffee Tea Soda
 Frequency: Daily Weekly Monthly
 Amount: 1 2 3 4 5 6 7 8 9

Tobacco Use: Never
 Type: Cigarettes Pipe Chew
 How much use daily? _____
 How long? _____ years
 Quit, when:

Illegal Drug Use: Never
 Type: Cocaine Opiates Amphetamine
 Marijuana Other
 Frequency: Daily Weekly Monthly
 Quit, when:

HEALTH MAINTANCE:

When was your last - Complete Physical Exam: n/a year _____ Dental exam: n/a year _____
 Lab work: n/a year _____ Chest X-Ray: n/a year _____
 Eye exam: n/a year _____ Colonoscopy: n/a year _____
 EKG: n/a year _____ Mammogram: n/a year _____

FAMILY HISTORY: Are you Adopted: no yes

Mother: Age: _____ Medical Conditions: _____
 Living / Deceased If deceased, cause of death: _____

Father: Age: _____ Medical Conditions: _____
 Living / Deceased If deceased, cause of death: _____



PATIENT'S NAME: _____ **D.O.B.** _____

Indicate relative by circling letter: Siblings: Circle **B**-(Brother), **S**-(Sister) Children: Circle **D**-(Daughter), **S**-(son):
age disease, if living *cause of death*

B	S	D	S	_____
B	S	D	S	_____
B	S	D	S	_____
B	S	D	S	_____
B	S	D	S	_____
B	S	D	S	_____
B	S	D	S	_____
B	S	D	S	_____
B	S	D	S	_____
B	S	D	S	_____

Have any of your blood relatives had the following disease? (Indicate relative by circling the letter under who):
F-(father), *M*-(mother), *GF*-(grandfather), *GM*-(grandmother), *B*-(brother), *S*-(sister), *C*-(child)

FAMILY DISEASES			no	yes	who	FAMILY DISEASES			no	yes	who
Anemia					<i>F M GF GM B S C</i>	High Blood Pressure					<i>F M GF GM B S C</i>
Alcoholism/Drug Use					<i>F M GF GM B S C</i>	High Cholesterol					<i>F M GF GM B S C</i>
Arthritis					<i>F M GF GM B S C</i>	HIV / AIDS					<i>F M GF GM B S C</i>
Asthma					<i>F M GF GM B S C</i>	Kidney problems					<i>F M GF GM B S C</i>
Back injury					<i>F M GF GM B S C</i>	Lung problems					<i>F M GF GM B S C</i>
Bleeding easily					<i>F M GF GM B S C</i>	Lupus					<i>F M GF GM B S C</i>
Blood Clots					<i>F M GF GM B S C</i>	Depression/anxiety					<i>F M GF GM B S C</i>
Cancer					<i>F M GF GM B S C</i>	Other Mental illness					<i>F M GF GM B S C</i>
Congenital disease					<i>F M GF GM B S C</i>	Osteoporosis					<i>F M GF GM B S C</i>
Diabetes					<i>F M GF GM B S C</i>	Seizures					<i>F M GF GM B S C</i>
Hay fever					<i>F M GF GM B S C</i>	Stomach problems					<i>F M GF GM B S C</i>
Heart conditions					<i>F M GF GM B S C</i>	Stroke					<i>F M GF GM B S C</i>
Headaches					<i>F M GF GM B S C</i>	Thyroid disease					<i>F M GF GM B S C</i>
Heart attack					<i>F M GF GM B S C</i>	Tuberculosis					<i>F M GF GM B S C</i>

REQUIRED IMMUNIZATIONS: *see attached copy*

MMR-(Measles, Mumps, Rubella) one dose after 12mo. of age 1. ____/____/____

TD-(Tetanus-Diphtheria booster) Td or Tdap in the past 10 years? 1. ____/____/____

RECOMMENDED IMMUNIZATIONS: *see attached copy*

Meningitis 1. ____/____/____ **Which one?** *Menactra Menomune Menveo*

Hepatitis A 1. ____/____/____ 2. ____/____/____

Hepatitis B 1. ____/____/____ 2. ____/____/____ 3. ____/____/____

(HPV) Gardasil 1. ____/____/____ 2. ____/____/____ 3. ____/____/____

Varicella - Either a history of chicken pox, two doses of the vaccine given at least one month apart if immunized after age 13, or copy of positive varicella antibody.

History of illness? *no yes* Dates of Vaccinations: 1. ____/____/____ 2. ____/____/____

History of reaction to immunization? *no yes* Which immunization? _____



PATIENT'S NAME: _____ **D.O.B.** _____

SYMPTOM / SYSTEMS REVIEW:

Have you had any of the following? (Please check no or yes, if so indicate how long.)

GASTROINTESTINAL				NEUROLOGICAL			
	no	yes	How long?		no	yes	How long?
Abdominal pain				Seizures			
Bloating				Headaches			
Belching				Numbness			
Heartburn/indigestion				Tingling of hands of feet			
Change of bowel habits				Tremors			
Blood in stools				Memory loss			
Rectal bleeding				Confusion			
Constipation				Dizziness			
Frequent Diarrhea				Loss of Consciousness			
Hemorrhoids (Piles)				Feeling Blue			
Gallbladder pain				INTEGUMENTARY			
Nausea/Vomiting				Recent hair loss			
Loss of appetite				New or change in mole			
Trouble swallowing				Change of color in skin			
Stomach pain				Change in hair or nails			
Painful bowel movements				Psoriasis			
EYES				Rash or itching			
	no	yes	How long?	Skin nodules or bumps			
Blurred or double vision				Skin changes after sun exposure			
Dryness				Warts/skin growth			
Redness of the eyes				RESPIRATORY			
Visual disturbance				Wheezing			
Wears glasses or contacts				Dry Cough			
GENITOURINARY				Coughing up mucus			
	no	yes	How long?	Cough up blood			
Burning or painful urination				Pain on breathing			
Protein in urine				Difficulty breathing			
Urinary frequency				Chronic cough			
Urination at night				CHEST / BREAST			
Prostate problems				Breast discharge			
Vaginal or penile discharge				Breast implants			
Genital rash or ulcers				Breast lumps			
Urine hesitancy				Breast tenderness			
Incontinence or dribbling							
Blood or pus in urine							



PATIENT'S NAME: _____ **D.O.B.** _____

MUSCULOSKELETAL				CARDIAC			
	no	yes	How long?		no	yes	How long?
Back pain				Chest pain			
Cold extremities				Swelling of feet			
Difficulty climbing stairs				Fast heart rate			
Difficulty Walking				Irregular heart rate			
Joint pain				Palpations			
Joint stiffness or swelling				Swelling of the hands			
Numbness or tingling				Heart trouble			
Muscle weakness				Leg Cramps			
Muscle tension				Poor circulation			
Paralysis				Fatigue			
Sleeping problems				HEAD / FACE			
Walk with a limp				Mouth sores/ulcer	no	yes	How long?
Walk with assisted device				Bleeding gums			
METABOLIC				Bad breath or bad taste			
	no	yes	How long?	Nosebleeds			
Chills / Fever				Ear pain			
Increase sweating				Frequent sore throats			
Increased thirst				Sinus tenderness			
Colder than other				Headaches			
Warmer than other				Lesion or scars			
Thyroid enlargement				Reduced facial strength			
Weight gain / loss				NECK			
	no	yes	How long?	Masses			
Masses				Facial paralysis			
Tenderness				Scalp tenderness			
Thyroid swelling				Difficulty swallowing			
Vein distention				Dentures			
Pain				Ringling in the ears			
				Hoarseness			
HEMATOLOGIC				Dryness of the mouth			
	no	yes	How long?				
Bleeding or bruising							
Enlarged glands							
Slow to heal cuts							
Jaundice (yellow skin)							

REMARKS:

Reviewed by Health Care Provider: _____ **Date:** _____