



Please fill in as much as you can to facilitate your examination.

Patients Name, Street Address, City, State & Zip, Phone #, Vocation/Title, Company Name, Spouse Name

Health Complaints: (Please list all symptoms) 1., 2., 3., 4.

Table with 2 columns: List Any Serious Medical Problems, DATE OF ONSET

Table with 2 columns: SURGERIES: List any operations you have had: TYPE, DATE

Table with 3 columns: MOST RECENT SCREENING PROCEDURES, DATE, RESULT

Date of last physical examination ___/___/___ Today's Date: ___/___/___

Age: _____ Never Married _____
D.O.B.: _____ Married _____
Ht.: _____ Divorced _____
Wt.: _____ Separated _____
Widow (er) _____

MEDICATIONS: List any medication you take regularly including over-the-counter & vitamins or minerals.

Table with 2 columns: NAME, DOSAGE

ALLERGIES: Are you allergic to any drugs? ___yes ___no

Table with 2 columns: NAME, REACTION

HABITS: Do you use tobacco? Do you drink alcohol? Do you drink caffeine? List any other recreational substances or other drugs you may use:

Do you exercise? _____ Describe _____

FAMILY HISTORY

Table with 8 columns: Please list names of family members. First & Last Name, Age, If Living Health, Age at Death, If Deceased Cause If Known, Has any Blood Relative Ever Had: Type, Who

PERSONAL HISTORY

YES

- High or Low blood pressure _____
- Gout _____
- Kidney Disease or Stones _____
- Bladder Disease _____
- Difficulty in Urinating _____
- Albumin, Sugar, Pus, etc. in Urine _____
- Abnormal Thirst _____
- Swelling of Hands, Feet or Ankles _____
- Scarlet Fever or Scarletina _____
- Pleurisy _____
- Rheumatic Fever or Heart Disease _____
- Arthritis or Rheumatism _____
- Any Bone or Joint Disease _____
- Neuritis or Neuralgia _____
- Bursitis, Sciatica or Lumbago _____
- Gonorrhea or Syphilis _____
- Anemia _____
- Learning Disabilities _____
- Emotional Problems _____
- Jaundice _____
- Epilepsy _____
- Migraine Headaches / Frequent Headaches _____
- Cancer _____
- Food, Chemical or Drug Poisoning _____
- Hay Fever or Asthma _____
- Hives or Eczema _____
- Frequent Infections or Boils _____
- Frequent Colds or Sore Throat _____
- Colon Polyps _____
- Any Other Disease _____
- Other; Please list _____

INJURIES: Have you had any: YES

- Broken or cracked bones _____
- Sprains _____
- Lacerations _____
- Dislocations _____
- Concussion or head injury _____
- Ever been knocked unconscious _____

WEIGHT: Now _____ One year ago _____
Maximum _____ When _____

EKG: Have you ever had an electrocardiogram _____
Abnormal _____

Do you now or have you had:

ENT: Eye disease, injury, impaired sight _____
Ear disease, injury, impaired hearing _____
Trouble with nose sinuses, mouth, throat _____

HEAD & NECK:
Fainting spells _____
Loss of consciousness _____
Convulsions _____
Paralysis _____
Dizziness _____
Frequent or severe headaches _____
Depression or anxiety _____
Hallucinations _____
Enlarged glands _____
Enlarged thyroid or goiter _____
Skin disease _____

CHEST:
Chronic or frequent cough _____
Chest pain or angina pectoris _____
Spitting up of blood _____
Night sweats _____
Shortness of breath _____
Palpitation or fluttering heart _____
Swelling of hands or feet _____
Extreme tiredness or weakness _____

G.I.:
Stomach trouble or ulcers _____
Indigestion _____
Liver or Gall Bladder disease _____
Colitis or other bowel disease _____
Hemorrhoids or rectal bleeding _____
Constipation or Diarrhea _____
Has there been any recent changes in:
Your appetite _____
Your action or stools _____
Bowels move regularly _____

G.U.:
Blood in urine _____
Burning _____
Fever, chills _____
Unable to control urine _____
Kidney or bladder stones _____

WOMEN ONLY

Menstrual history:
Age at onset _____
Regular _____ No ___ Yes ___
Days of Menstrual Cycle (ex 28 days) _____
Usual duration of period # days _____
Average # of tampons or pads used per day _____
Pain or cramps _____ No ___ Yes ___
Date of last period _____
of Pregnancies _____
How many children born alive _____
Currently using contraception? _____ No ___ Yes ___
What type? _____
Any family history of breast or GYN Cancer? No ___ Yes ___
Date of last mammogram _____
Results _____
Date of Last Pap _____
Results _____
Your age when your first child was delivered _____
History of breast biopsy _____ No ___ Yes ___

Results _____

FOR MEN ONLY: Have you had

YES
Prostatitis _____
Testicular pain _____
Urethral discharge _____
Infertility _____
Premature ejaculation _____
Difficulty with erection _____

X-RAYS: Have you ever had any x-rays of:
Kidneys _____
Chest _____
Stomach or colon _____
Extremities _____
Back _____
Please list any abnormal findings:

