Date_____

Name: _____ **DOB:** _____ **Age:** _____

Chief Complaint: _____

_____

Past Medical History

_____
_____
_____
_____

Past Surgical History

_____
_____
_____
_____

List all allergies of any kind and include reactions:

_____
_____

Present Medications: (Please include prescriptions and non-prescription medications.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Obstetrical History: Last normal menstrual period : _____ # of pregnancies: _____

# of children: _____ Age at first live birth: _____ Gestational Diabetes (Y/N): _____

Social History/ Habits:

Relationship Status: Single _____ Married _____ Separated _____ Divorced _____ Widowed _____

Occupation: _____ How long at this employer: _____

Tobacco: Y/N_____ Chew _____ Smoke _____ Amount per day: _____
Former Smoker: Y/N _____ When did you quit? _____
Street Drugs: Y/N _____ If yes, what type: _____
Exercise: Y/N _____ Times per week: _____ Caffine: _____
Alcohol: Y/N _____ How many drinks per day? _____ Times per week? _____

Family History:

Check if any blood relatives(mother, father, brother, sister, maternal/paternal grandmothers, grandfathers, children) have any of the following: Use these symbols in the WHO column if yes is indicated: M, F, B, S, MGM/MGF, PGM/PGF, C

	Yes	No	Who		Yes	No	Who		Yes	No	Who
Stroke				Epilepsy				Diabetes			
Cancer				Emphysema				Kidney Disease			
High Blood Pressure				Bleeding Tendency				Heart Disease			
Melanoma				Arthritis				Died Suddenly/Age?			

Health Maintenance:

Last Mammogram Date: _____ Result: _____
Last Colonoscopy Date: _____ Result: _____
Last Pap Smear Date: _____ Result: _____
Last PSA Date: _____ Result: _____
Last Tetanus Date: _____ Result: _____

Please check indicating if you have or have had problems with any of the following and describe in the space provided.

GENERAL HEALTH	YES	NO	COMMENTS
Fever			
Chills			
Fatigue or tiredness			
Cancer			
Unexplained weight gain or loss			
EYES			
Disease/Injury			
Blurred Vision			
Double Vision			
Glaucoma			
EARS/NOSE/MOUTH/THROAT			
Hearing Loss			
Ringing in the Ears			
Earaches/Drainage			
Nosebleeds			
Chronic Sinus Problems			
Mouth Sores			
Sore Throat			
Voice Changes			
Swollen Neck Glands			
CARDIOVASCULAR			
Heart Trouble			
Chest Pain/Angina			
Rheumatic Fever			
Irregular or fast hearbeat			
High Blood Pressure			
Swelling of Feet/Hands			
RESPIRATORY			
Shortness of Breath			
Coughing			
Spitting up Blood			
Asthma/Wheezing			
GASTROINTESTINAL			
Change in Bowel Movements			
Nausea/Vomitting			
Frequent Diarrhea			
Rectal Bleeding/Blood in Stool			
Abdomnial Pain/Heartburn			
Peptic or Stomach Ulcers			
Colitis			
Gallbladder Disease			
GENITOURINARY			
Frequent Urination			
Burning/Painful Urination			
Blood in Urine			
Incontinence or Dribbling			
Kidney Stones			
Sexual Difficulty			
Male-Testicle Pain			
Female- Irregular Periods			
Female-Planning Pregnancy			
Female-Menopause			
Sexually Transmitted Disease			

MUSCULOSKELETAL	YES	NO	COMMENTS
Joint Pain			
Muscle Pain			
Muscle Weakness			
Joint Stiffness/Cramping			
Gout			
Arthritis			
SKIN/BREAST			
Rash or Itching			
Change in Skin Color			
Change in Hair/Nail Color			
Varicose Veins			
Breast Pain			
Female – Breast Discharge			
NEUROLOGICAL			
Stroke			
Frequent Headache			
Lightheadedness/Dizziness			
Seizures			
Numbness/Tingling			
Tremors			
Head Injury			
Blackout/Loss of Consciousness			
PSYCHIATRIC			
Nervousness			
Depression			
Insomnia			
ENDOCRINE			
Hormone Problem			
Thyroid Disease			
Diabetes			
Excessive Thirst			
Excessive Urination			
Heat/Cold Intolerance			
Dry Skin			
HEMATOLOGY/LYMPHATIC			
Slow to Heal After Cuts			
Bleeding or Bruising Tendency			
Anemia			
Past Transfusions			
Enlarged Glands			
Jaundice			
Hepatitis			
ALLERGIC/IMMUNOLOGIC			
Food Allergies			
Enviromental Allergies			
Latex Allergies			