TODAY'S DATE

NAME ________________________________

Last Middle First

AGE ______ DATE OF BIRTH ____________

OCCUPATION ____________________

EDUCATION ____________

C.C. Please list all your reasons for visit

1. ____________________________
2. ____________________________
3. ____________________________
4. ____________________________
5. ____________________________
6. ____________________________

Last Blooc! Test Date: ____________________

Last Mammogram Date: ____________________

Last BMD Date: ____________________

Last Flu Vaccine Date: ____________________

PERSONAL HISTORY

ILNESSES: have you ever had:

Check answers by 'X' no or yes Date

| Illness | | | Date |
|---|---|---|---|
| High blood pressure | no | yes | |
| Low blood pressure | | | ________ |
| Heart disease | no | yes | ________ |
| Heart attack | no | yes | ________ |
| | no | yes | ________ |
| Blood clots | no | yes | ________ |
| Phlebitis | no | yes | ________ |
| Stroke | no | yes | ________ |
| Diabetes | no | yes | ________ |
| Gout | no | yes | ________ |
| Sinusitis | no | yes | ________ |
| Asthma | no | yes | ________ |
| Emphysema | no | yes | ________ |
| Bronchitis | no | yes | ________ |
| Stomach ulcer | no | yes | ________ |
| Duodenal ulcer | no | yes | ________ |
| Colitis | no | yes | ________ |
| Gall bladder disease | no | yes | ________ |
| Gall bladder stones | no | yes | ________ |
| Kidney stones | no | yes | ________ |
| Kidney infection | no | yes | ________ |
| Bladder infection | no | yes | ________ |
| Cirrhosis of liver | no | yes | ________ |
| Tuberculosis | no | yes | ________ |
| Abnormal Pap smear | no | yes | ________ |
| HPV Infection | no | yes | ________ |
| Gardasil vaccine | no | yes | |
| Cancer | no | yes | ________ |
| Goiter | no | yes | ________ |
| Epilepsy | no | yes | ________ |
| Nervous breakdown | no | yes | ________ |
| Gonorrhea | no | yes | ________ |
| Syphilis | no | yes | ________ |
| Polio | no | yes | ________ |
| Anemia | no | yes | ________ |
| Mumps | no | yes | ________ |
| Rheumatic fever | no | yes | ________ |
| German measles | no | yes | ________ |
| Chicken pox | no | yes | ________ |

Any other disease

________________________________

________________________________

________________________________

ALLERGIES: Are you allergic to:

| Drug | | | |
|---|---|---|---|
| Penicillin | no | yes | ________ |
| Sulfa | no | yes | ________ |
| Aspirin | no | yes | ________ |
| Codeine | no | yes | ________ |

Any other drug

________________________________

________________________________

________________________________

________________________________

SURGICAL HISTORY: have you ever had any of the following:

Check answers Date

| Operation | | | Date |
|---|---|---|---|
| Tonsillectomy | no | yes | ________ |
| Appendix operation | no | yes | ________ |
| Hernia operation | no | yes | ________ |
| Hemorrhoid operation | no | yes | ________ |
| Stomach operation | no | yes | ________ |
| Gall bladder operation | no | yes | ________ |
| Varicose vein operation | no | yes | ________ |
| Thyroid operation | no | yes | ________ |
| Breast operation | no | yes | ________ |
| Hysterectomy operation | no | yes | ________ |
| Cesarean section | no | yes | ________ |
| Removal of ovaries | no | yes | ________ |

Any other operation:

________________________________

________________________________

________________________________

________________________________

| FAMTLY HISTORY | | Age | If living health | Age | If Deceased cause | Has any blood relative ever had | Who | Age at onset |
|---|---|---|---|---|---|---|---|---|
| Father | | | | | | Cancer no yes | | |
| Mother | | | | | | Tuberculosis no yes | | |
| # of Brothers/ Age | | | | | | Diabetes no yes | | |
| # of Sisters/Age | | | | | | heart trouble no yes | | |
| | | | | | | High blood Pressure no yes | | |
| Husband/Wife | | | | | | Stroke no yes | | |
| Son/Daughter 1 | | | | | | Epilepsy no yes | | |
| 2 | | | | | | Insanity no yes | | |
| 3 | | | | | | Suicide no yes | | |

Patient's Name:

Sexual History

Check answers

Sexually active no yes ________
# Partners ________
Gender ________
Male no yes ________
Female no yes ________

SYSTEMS: Do you now have or have you ever had long standing:
Check answers Date
Cough no yes ________
Sputum (phlegm) no yes ________
Shortness of breath no yes ________
Chest pain no yes ________

Palpitation no yes ________
Angina no yes ________

Appetite excellent good poor
Nausea no yes ________
Vomiting no yes ________
Diarrhea no yes ________
Constipation no yes ________
Abdominal pain no yes ________
Gas pain no yes ________
Heartburn no yes ________
Blood in stools no yes ________

Headache no yes ________
Dizziness no yes ________
Fainting spells no yes ________
Seizures no yes ________
Muscles weakness no yes ________
Numbness, tingling no yes ________

Impaired hearing no yes ________
Impaired vision no yes ________
Do you wear glasses? no yes ________
Do you wear contact lenses? no yes ________

Do you urinate frequently? no yes ________
Do you bum when urinating? no yes ________
Do you have difficulty urinating? no yes ________
Does your urine have a bad smell? no yes ________
Has there been a change in color of urine? no yes ________

Do you bleed easily? no yes ________
Do you bruise easily? no yes ________

Fever no yes ________
Weight loss no yes ________
Weight gain no yes ________
Lack of energy & "pep" no yes ________
Do you feel tired all the time? no yes ________
Do you sleep well? no yes ________

Vaginal bleeding no yes ________
Vaginal discharge no yes ________
Vaginal itching no yes ________

STREET DRUGS:

Have you ever tried street drugs? no yes ________
If yes, name of drugs used: ________

If discontinued, when: ________
Number of years used: ________

AVERAGE AMOUNT OF SMOKJNG THROUGHOUT LIFE:

Tobacco: cigarettes: ________ Cigarettes per day
________ Number of years
Last Smoked: (MM/YY): ________

ALCOHOLIC BEVERAGES:
Never rarely moderate heavily

Number of year's ________ beer
Number of drinks per day ________ wine
Other

YOUR SEX Life is:
Excellent Satisfactory unsatisfactory poor none
Explain: ________

DO YOU TAKE MEDICINE REGULARLY?
No yes
Name of medicines:
________
________

NAMES OF PHYSICIANS THAT ARE Familiar WITH YOUR MEDICAL CONDITIONS:
________
________

CONTRACEPTIVE HISTORY:
Have you ever taken birth control pills? No yes discontinued
# of years you took pills ________
If discontinued, when & why ____
Current birth control in use ________

MENSTRUAL HISTORY:

Age at onset ________
Regular no yes
Cycle: ________ days (from start to start)
Usual duration ________ days
Heavy medium light
Pains or cramps no yes
Date of last period ________

DATE OF LAST "PAP" SMEAR: ________

PREGNANCIES:

How many pregnancies ________
How many children born alive ________
How many stillbirths ________
How many prematures ________
How many cesarean sections ________
How many miscarriages ________
How many abortions ________
Any complications with any pregnancy no yes

AGE & YEAR WHEN PERIODS STOPPED:

Permanently -menopause (if applicable) ________
Age year ________

ANY OTHER CONCERNS:
________
________
________
________