DATE: __________

NAME: ____________________ AGE: ________ DOB: ____________________

REFERRING PHYSICIAN: ____________________ LOCATION: ____________________

PRIMARY CARE PHYSICIAN: ____________________ LOCATION: ____________________

REASON FOR APPOINTMENT: ____________________

MEDICATIONS: ____________________

____

ALLERGIES: ____________________

PAST SURGICAL HISTORY: ____________________

____

HAVE YOU EVER RECEIVED DONOR BLOOD? YES ______ WHEN? ______ NO ______

HAVE YOU CONSULTED THE FOLLOWING?

CARDIOLOGIST ____ YES ____ NO DR.__________________
PULMONOLOGIST ____ YES ____ NO DR.__________________
NEUROLOGIST ____ YES ____ NO DR. __________________
GASTROENTEROLOGIST ____ YES ____ NO DR. __________________

PAST FAMILY HISTORY:

	MOTHER	FATHER	G-PARENTS	SIBLING	SELF
HEART ATTACK					
RHEUMATIC FEVER					
STROKE/TIA(MINI-STROKE)					
HIGH BLOOD PRESSURE					
HIGH CHOLESTEROL					
CANCER (TYPE & LOCATION)					
DIABETES					
TUBERCULOSIS					
BLEEDING DISORDER					
EMPHYSEMA					
ASTHMA					
BRONCHITIS					

	MOTHER	FATHER	G-PARENTS	SIBLING	SELF
PULMONARY EMBOLUS					
DEEP VENOUS THROMBOSIS					
ARTHRITIS					
GOUT					
ULCERS					
GALLSTONES					
KIDNEY STONES					
LIVER DISEASE					
ALCOHOLISM					

MOTHER LIVING? YES ____ NO ____ CAUSE OF DEATH? _________________

FATHER LIVING? YES ____ NO ____ CAUSE OF DEATH? _________________

WOMEN ONLY:

NUMBER OF PREGNANCIES? ______ NUMBER OF MISCARRIAGES/ABORTIONS? _________
DATE OF LAST MENSTRUAL PERIOD? _______ DATE OF LAST MAMMOGRAM? __________

SOCIAL HISTORY:

_____ MARRIED _____SINGLE ______ WIDOWED _____ DIVORCED ____ SEPARATED

NUMBER OF CHILDREN: ____

FAMILY MEMBERS IN THE HOME: ____

DISABLED? _____YES REASON? ____________________________________ NO ___________________

CURRENTLY EMPLOYED? _____ YES _____ NO IF YES, WHERE AND JOB DESCRIPTION?
____

HAVE YOU EVER BEEN EXPOSED TO THE FOLLOWING?

_____ TUBERCULOSIS _____ HIV ______ EXHAUST DUST _____ ASBESTOS ______ TOXIC FUMES

HABITS?

DO YOU EXERCISE? _____ YES ______ NO IF YES, HOW OFTEN? ________________________
ALCOHOLIC BEVERAGES? ______YES ______ NO HOW OFTEN?_______________________________
HOW MUCH? ____________ WHAT TYPE? ______________________________

DO YOU USE DRUGS? (I.E. COCAIN, MARIJUANA) _______ YES ______ NO IF YES, WHAT TYPE?
____

DO YOU SMOKE? YES _______ PACKS/DAY? ________ YEARS? ___________________________________
NO _______ WHEN DID YOU QUIT? ____
ANY OTHER TOBACCO PRODUCTS? ____

IS THERE ANYTHING YOU FEEL PERTINENT TO YOUR MEDICAL HISTORY THE DOCTOR SHOULD BE AWARE OF? ____

HEALTH HISTORY

NAME: ____________________________ TODAY'S DATE: _____________________________

AGE: _____ BIRTHDATE: ___________ DATE OF LAST PHYSICAL EXAM: ____________

SYMPTOMS: CHECK ( ) ANY SYMPTOMS YOU CURRENTLY HAVE OR HAVE HAD IN THE PAST YEAR.

GENERAL :

[ ] CHILLS
[ ] PASSING OUT
[ ] DEPRESSION
[ ] DIZZINESS
[ ] FAINTING
[ ] FEVER
[ ] FORGETFULNESS
[ ] HEADACHE
[ ] LOSS OF SLEEP
[ ] LOSS OF WEIGHT
[ ] NERVOUSNESS
[ ] NUMBNESS
[ ] SWEATS

MUSCLE/JOINT/BONE:

[ ] ARMS
[ ] HIPS
[ ] BACK
[ ] LEGS
[ ] FEET
[ ] NECK
[ ] HANDS
[ ] SHOULDERS

GENITO-URINARY

[ ] BLOOD IN URINE
[ ] FREQUENT URINATION
[ ] LACK OF BLADDER CONTROL
[ ] PAINFUL URINATION

GASTROINTESTINAL:

[ ] POOR APPETITE
[ ] BLOATING
[ ] BOWEL CHANGES
[ ] CONSTIPATION
[ ] DIARRHEA
[ ] EXCESSIVE HUNGER
[ ] EXCESSIVE THRIST
[ ] GAS
[ ] HEMORRHOIDS
[ ] INDIGESTION
[ ] NAUSEA
[ ] RECTAL BLEEDING
[ ] STOMACH PAIN
[ ] VOMITING
[ ] VOMITING BLOOD

CARDIOVASCULAR:

[ ] CHEST PAIN
[ ] HIGH BLOOD PRESSURE
[ ] IRREGULAR HEART BEAT
[ ] LOW BLOOD PRESSURE
[ ] POOR CIRCULATION
[ ] RAPID HEART BEAT
[ ] SWELLING OF ANKLES
[ ] VARICOSE VEINS
[ ] PAIN IN LEGS WHEN WALKING

EYE, EAR NOSE THROAT:

[ ] BLEEDING GUMS
[ ] BLURRED VISION
[ ] CROSSED EYES
[ ] DIFFICULTY SWALLOWING
[ ] DOUBLE VISION
[ ] EARACHE
[ ] HAY FEVER
[ ] HOARSENESS
[ ] LOSS OF HEARING
[ ] NOSEBLEEDS
[ ] VISION HALOS
[ ] RINGING IN EARS
[ ] SINUS PROBLEMS
[ ] VISION FLASHES

SKIN:

[ ] BRUISE EASILY
[ ] HIVES
[ ] ITCHING
[ ] CHANGES IN MOLES
[ ] RASH
[ ] SCARS
[ ] SORE THAT WON'T HEAL

MEN ONLY:

[ ] BREAST LUMP
[ ] ERECTION DIFFICULTIES
[ ] LUMP IN TESTICLES
[ ] PENIS DISCHARGE
[ ] SORE ON PENIS
[ ] OTHER_________________

WOMEN ONLY:

[ ] ABNORMAL PAP SMEAR
[ ] BLEEDING BETWEEN PERIODS
[ ] BREAST LUMP
[ ] EXTREME MENSTRUAL PAIN
[ ] HOT FLASHES
[ ] NIPPLE DISCHARGE

PULMONARY:

[ ] COUGH
[ ] SHORT OF BREATH
[ ] WHEEZING
[ ] HOME OXYGEN
[ ] SLEEP APNEA

CONDITIONS: CHECK ( ) CONDITIONS YOU HAVE OR HAVE HAD IN THE PAST :

[ ] AIDS
[ ] ALCOHOLISM
[ ] ANEMIA
[ ] ANOREXIA
[ ] APPENDICITIS
[ ] ARTHRITIS
[ ] ASTHMA
[ ] BLEEDING DISORDERS
[ ] BREAST LUMP
[ ] BRONCHITIS
[ ] BULIMIA
[ ] CANCER
[ ] CATARACTS
[ ] CHEMICAL DEPENDENCY
[ ] CHICKEN POX
[ ] DIABETES
[ ] EMPHYSEMA
[ ] EPILEPSY
[ ] GLAUCOMA
[ ] GOITER
[ ] GONORRHEA
[ ] GOUT
[ ] HEART DISEASE
[ ] HEPATITIS
[ ] HERNIA
[ ] HERPES
[ ] HIGH CHOLESTEROL
[ ] HIV POSITIVE
[ ] KIDNEY DISEASE
[ ] LIVER DISEASE
[ ] MEASLES
[ ] MIGRAINE HEADACHES
[ ] MISCARRIAGE
[ ] MONONUCLEOSIS
[ ] MULTIPLE SCLEROSIS
[ ] MUMPS
[ ] PACEMAKER
[ ] PNEUMONIA
[ ] POLIO
[ ] PROSTATE PROBLEMS
[ ] PSYCHIATRIC CARE
[ ] RHEUMATIC FEVER
[ ] SCARLET FEVER
[ ] STROKE
[ ] SUICIDE ATTEMPT
[ ] THYRIOD PROBLEM
[ ] TONSILLITIS
[ ] TUBERCULOSIS
[ ] TYPHOID FEVER
[ ] ULCERS
[ ] VAGINAL INFECTIONS
[ ] VENEREAL DISEASE