Name: _____

Age: _____ Birth Date:____/____/____ Date of last physical examination:____/____/____

What is your reason for visit? _____

SYMPTOMS: Check (✓) symptoms you currently have or have had in the past year:

GENERAL
- ❑ Chills
- ❑ Depression
- ❑ Dizziness
- ❑ Fainting
- ❑ Forgetfulness
- ❑ Headaches
- ❑ Loss of Sleep
- ❑ Loss of Weight
- ❑ Nervousness
- ❑ Numbness
- ❑ Sweats

MUSCLE/JOINT/BONE
Pain, weakness, numbness in:
- ❑ Arms
- ❑ Back
- ❑ Feet
- ❑ Hands
- ❑ Hips
- ❑ Legs
- ❑ Neck
- ❑ Shoulders

GENITO-URINARY
- ❑ Blood in Urine
- ❑ Frequent Urination
- ❑ Lack of Bladder Control
- ❑ Painful Urination

GASTROINTESTINAL
- ❑ Appetite Poor
- ❑ Bloating
- ❑ Bowel Changes
- ❑ Constipation
- ❑ Excessive Hunger
- ❑ Excessive Thirst
- ❑ 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

EYE, EAR, NOSE, THROAT
- ❑ Bleeding Gums
- ❑ Blurred Vision
- ❑ Crossed Eyes
- ❑ Difficulty Swallowing
- ❑ Earache
- ❑ Ear Discharge
- ❑ Hay Fever
- ❑ Hoarseness
- ❑ Loss of Hearing
- ❑ Nosebleeds
- ❑ Persistent Cough
- ❑ Ringing in Ears
- ❑ Sinus Problems
- ❑ Vision - Flashes
- ❑ Vision - Halos

SKIN
- ❑ Bruise easily
- ❑ Hives
- ❑ Itching
- ❑ Change in moles
- ❑ Rash
- ❑ Scars
- ❑ Sore that won't heal

MEN ONLY
- ❑ Breast Lump
- ❑ Erection Difficulties
- ❑ Lump in Testicles
- ❑ Penis Discharge
- ❑ Other

Women Only
- ❑ Abnormal Pap Smear
- ❑ Bleeding between periods
- ❑ Breast Lump
- ❑ Extreme Menstrual Pain
- ❑ Hot Flashes
- ❑ Nipple Discharge
- ❑ Painful Intercourse
- ❑ Vaginal Discharge
- ❑ Other

Date of last menstrual period:___/___/___

Date of last Pap Smear:___/___/___

Have you had a mammogram? ❑ yes ❑ no

Are you pregnant? ❑ yes ❑ no ❑ not sure

Number of Children:_____

CONDITIONS: Check (✓) conditions you have or have had in the past year:

- ❑ 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
- ❑ Miscarriages
- ❑ Mononucleosis
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Pneumonia
- ❑ Polio
- ❑ Prostate Problem
- ❑ Psychiatric Care
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Stroke
- ❑ Suicide Attempt
- ❑ Thyroid Problems
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Typhoid Fever
- ❑ Ulcers
- ❑ Vaginal Infections
- ❑ Venereal Disease

FAMILY HISTORY Fill in health information about your family

Relation	Age	State of Health	Age at of Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if, your blood relative had any of the following:

	Disease	Relationship to you
	Arthritis, Gout	
	Asthma, Hay Fever	
	Cancer	
	Chemical Dependency	
	Diabetes	
	Heart Disease, Stroke	
	High Blood Pressure	
	Kidney Disease	
	Tuberculosis	
	Other	

HOSPITALIZATIONS

Year	Hospital	Reason for Hospitalization and Outcome	NUMBER OF BIRTHS	Complications, if any:

Have you ever had a blood transfusion? Yes ☐ No ☐
If yes. Please give approximate date: _____

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

HEALTH HABITS

Check (✓) Which substance you use and describe how much you use:

	Caffeine
	Tobacco
	Drugs
	Other

OCCUPATIONAL CONCERNS

Check (✓) If your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other

Your Occupation:

Signature: _____