Name			RaceSex	Age	
HandednessL	R	Height	Weight		
Present Concerns:					
resent concerns.	-				
		Past Med	dical History		
Have you ever had:					
Chicken Pox	No	Yes When	Hepatitis	NoYes When	
Scarlet Fever	No No	Yes When	Tuberculosis	NoYes When	
Rheumatic Fever	No	Yes When	Pneumonias	NoYes When	
Polio	No No	Yes When	Venereal Disease	No Yes When	
Blood Transfusions	No				
Have you ever been treated	for:				
Asthma	No		Thyroid Disease _	NoYes When	
Emphysema	No			NoYes When	
Heart Attack	No				
Heart Failure	No	Yes When		NoYes When	
Heart Murmur	No	Yes When	Kidney Disease	NoYes When	
Abnormal Heartbeat	No No	Yes When	Kidney Stone	NoYes When	
High Blood Pressure	No		Ulcer Disease	NoYes When	
Colitis	No	Yes When	Gall Bladder		
Blood Clots	No No		Disease	NoYes When	
Arthritis	No	Yes When	Stroke	NoYes When	
Gout	No			NoYes When	
Abnormal Cholesterol			Psychiatric Disorder _		
Chronic Allergies,	· 110	103 WHOH	Glaucoma	NoYes When	
Hay Fever	No	Yes When		NoYes When	
Other problems not listed al	bove				
Last Colonscopy			Last Stress Test		
List any operations that you	ı have had (inc	lude approximate	age):		
Have you ever been treated	with X-RAY the	erapy or radioactiv	ve drugs?No _	Yes When	
List any medications (and d	losages) you c	urrently are taking	(include over-the-counter dru	gs):	
_					
liet medication allowing					
List medication allergies					

Habits						
Tobacco use?	No	Yes	How many packs per day?			
Did you quit?	No	Yes	How many packs per years?			
If so, When?						
Alcohol?	No	Yes	Amount per day?			
Coffee, tea or cola?		Yes	Amount per day?			
Do you exercise regularly?	No	Yes	How often?			
	110	103	How often:			
What kind of work						
do you do?			Any toxic exposure?	No	Yes	
What method of contraception of	do vou us	se(if applicable)?	<del>.</del>			
	-					
Do any of your family members h	ave or h	ave had:	Family History:	Age	Illness	
Cancer	No	Yes	Father			
Heart Attacks	No	Yes	Mother			
High blood pressure	No	Yes	Brothers			
					-	
Strokes	No	Yes	Sisters			
Thyroid disease	No	Yes	Sons			
Diabetes	No	Yes	Daughters			
Anemia	No	Yes	Other			
Kidney disease	No	Yes				
Ulcers	No	Yes				
Other	No	Yes				
Are you bothered with:						
-						
Skin Rashes or Discoloration	No	Yes	Loss of Consciousness	٠	No	Yes
Abnormal Lumps or Glands	No	Yes	Unusual or Serious Vis	sual Problems	No	Yes
Nausea or Vomiting	No	Yes	Hearing, Problems, Earaches		No	Yes
Belly Pain	No	NoYes Headaches			No	Yes
Constipation	No	Yes	Frequent Colds		No	Yes
Diarrhea	No	Yes	Hoarseness	Hoarseness		Yes
Bloody or Tarry Stools	No	Yes	Frequent or Persistent	Cough	No	Yes
Excessive or Constant Worrying	No	Yes	Feeling Lonely or Depressed		No	Yes
Abnormal Tiredness			Inability to Sleep Well		No	Yes
Shortness of Breath	No	Yes Yes	Mood Swings		No	Yes
Wheezing	No	Yes	Poor Appetite		No	Yes
Chest Pain	No	Yes	Difficulty Swallowing		No	Yes
Skipped or Irregular Heartbeat	No	Yes	Hemorrhoids		No	Yes
Ankle Swelling	No	Yes	Trouble Urinating		No	Yes
Pain in your Legs when you walk		Yes	Arthritis		No	Yes
Weakness in your Arms or Legs	No	Yes	Morning Stiffness		No	Yes
Loss of Sensation (numbness)	No	Yes	Fever or Chills	I D:#:It	No	Yes
Lightheadedness	No		Impotence or Other Se	exual Difficulty	No	Yes
Night Sweats	No	Yes	Bruises		No	Yes
Weight Loss	No	Yes	Weight Gain		No	Yes
Places give details of any year any		of other aumoten	no not listed shove			
Please give details of any yes ans	swers or	or other sympton	ns not listed above			
Please list any other doctors you	currentl	y see:				
		_				
Fomala Patients - De vou heve en	v proble	me with:				
Female Patients - Do you have an	y brobie	ins with:				
Cramps	No	Yes	Heavy Bleeding		No	
Oramps		Yes	Discharge		No	Yes
	INO		Last Breast Exam/Mammogram			
Irregular Painful intercourse			Last Breast Exam/Ma	ammogram		
Irregular Painful intercourse	No	Yes		ammogram		
Irregular	No		Last Pap Smear	-		
Irregular Painful intercourse	No	Yes	Last Pap Smear Last Bone Density So	-		

Signed

Date