Name _____ **Race** _____ **Sex** _____ **Age** _____

Handedness _____**L** _____**R** **Height** _____ **Weight** _____

Present Concerns: _____

Past Medical History

Have you ever had:

Chicken Pox	_____ No	_____Yes When _____		Hepatitis	_____No	_____Yes When _____	
Scarlet Fever	_____ No	_____Yes When _____		Tuberculosis	_____No	_____Yes When _____	
Rheumatic Fever	_____ No	_____Yes When _____		Pneumonias	_____No	_____Yes When _____	
Polio	_____ No	_____Yes When _____		Venereal Disease	_____No	_____Yes When _____	
Blood Transfusions	_____ No	_____Yes When _____					

Have you ever been treated for:

Asthma	_____ No	_____Yes When _____		Thyroid Disease	_____No	_____Yes When _____	
Emphysema	_____ No	_____Yes When _____		Diabetes	_____No	_____Yes When _____	
Heart Attack	_____ No	_____Yes When _____		Anemia	_____No	_____Yes When _____	
Heart Failure	_____ No	_____Yes When _____		Cancer	_____No	_____Yes When _____	
Heart Murmur	_____ No	_____Yes When _____		Kidney Disease	_____No	_____Yes When _____	
Abnormal Heartbeat	_____ No	_____Yes When _____		Kidney Stone	_____No	_____Yes When _____	
High Blood Pressure	_____ No	_____Yes When _____		Ulcer Disease	_____No	_____Yes When _____	
Colitis	_____ No	_____Yes When _____		Gall Bladder			
Blood Clots	_____ No	_____Yes When _____		Disease	_____No	_____Yes When _____	
Arthritis	_____ No	_____Yes When _____		Stroke	_____No	_____Yes When _____	
Gout	_____ No	_____Yes When _____		Epilepsy(seizures)	_____No	_____Yes When _____	
Abnormal Cholesterol	_____ No	_____Yes When _____		Psychiatric Disorder	_____No	_____Yes When _____	
Chronic Allergies,				Glaucoma	_____No	_____Yes When _____	
Hay Fever	_____ No	_____Yes When _____		Colon Polyps	_____No	_____Yes When _____	

Other problems not listed above _____

Last Colonscopy _____ **Last Stress Test** _____

List any operations that you have had (include approximate age): _____

Have you ever been treated with X-RAY therapy or radioactive drugs? _____No _____Yes When _____

List any medications (and dosages) you currently are taking (include over-the-counter drugs):

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?	No_____ Yes_____	Amount per day?	_____
Do you exercise regularly?	No_____ Yes_____	How often?	_____
What kind of work do you do?	_____	Any toxic exposure?	No_____ Yes_____

What method of contraception do you use(if applicable)? _____

Do any of your family members have or have 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(Fainting)	No_____ Yes_____
Abnormal Lumps or Glands	No_____ Yes_____	Unusual or Serious Visual Problems	No_____ Yes_____
Nausea or Vomiting	No_____ Yes_____	Hearing, Problems, Earaches	No_____ Yes_____
Belly Pain	No_____ Yes_____	Headaches	No_____ Yes_____
Constipation	No_____ Yes_____	Frequent Colds	No_____ Yes_____
Diarrhea	No_____ Yes_____	Hoarseness	No_____ 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	No_____ Yes_____	Inability to Sleep Well	No_____ Yes_____
Shortness of Breath	No_____ 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	No_____ 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	No_____ Yes_____
Lightheadedness	No_____ Yes_____	Impotence or Other Sexual Difficulty	No_____ Yes_____
Night Sweats	No_____ Yes_____	Bruises	No_____ Yes_____
Weight Loss	No_____ Yes_____	Weight Gain	No_____ Yes_____

Please give details of any yes answers or of other symptoms not listed above _____

_____

_____

Please list any other doctors you currently see: _____

_____

_____

Female Patients - Do you have any problems with:

Cramps	No_____ Yes_____	Heavy Bleeding	No_____ Yes_____
Irregular	No_____ Yes_____	Discharge	No_____ Yes_____
Painful intercourse	No_____ Yes_____	Last Breast Exam/Mammogram	_____
Your last menstrual period?	_____	Last Pap Smear	_____
		Last Bone Density Scan	_____

Number of pregnancies and any complications _____

Signed _____ **Date** _____