PATIENT NAME: ______________________ DATE COMPLETED: ______________

DATE OF BIRTH: ______________________ SEX: Male ☐ Female ☐

MEDICAL HISTORY: *(Please check all items that apply to you.)*

☐ Difficulty sleeping
☐ Nervousness
☐ Depression
☐ Severe stress
☐ Memory loss
☐ Mental illness
☐ Problems with vision
☐ Hearing problems
☐ Frequent nose bleeds
☐ Sinus / hay fever / allergy
☐ Cough
☐ Hoarseness
☐ Breast lump
☐ Lump in testicles

☐ Breathing problems
☐ Asthma
☐ Thyroid disease
☐ Rheumatic fever
☐ Chest pain
☐ High blood pressure
☐ Heart problems
☐ Varicose veins / phlebitis
☐ Heart attack (what year?) ______
☐ Arthritis / gout
☐ Painful joints
☐ Loss of appetite
☐ Abnormal Pap Smear
☐ Hot flashes

☐ Weight gain or loss
☐ Eating problems
☐ Indigestion / heartburn
☐ Stomach problems
☐ Frequent nausea / vomiting
☐ Changes in bowel habits
☐ Diarrhea or constipation
☐ Anemia
☐ Diabetes
☐ Gallbladder disease
☐ Kidney / bladder problems
☐ Blood in urine
☐ Vaginal discharge
☐ Penis discharge

☐ Swelling (where?) ______
☐ Weakness (where?) ______
☐ Difficulty or pain when urinating
☐ Black or blood bowel movements
☐ Numbness (where?) ______
☐ Pain (where?) ______
☐ TB (Tuberculosis)
☐ Cancer (Where? ______)
☐ Sexually transmitted disease
☐ Severe / unusual headache
☐ Skin problems / changes
☐ Bleeding disorder/bruise easily
☐ Bleeding between periods
☐ Extreme menstrual pain

☐ Prostate disease
☐ Frequent infections
☐ Problems with teeth/gums
☐ Rectal bleeding
☐ Convulsions / seizures
☐ Polio
☐ Sexual problems
☐ Stroke
☐ HIV Exposure
☐ Hepatitis B
☐ Hepatitis C
☐ Other: ______
☐ Nipple discharge
☐ Painful intercourse

Please indicate the date of your:

Last Tetanus Shot ______
Last Pneumonia Shot ______
Last MMR Shot ______
Last Hepatitis B Shot ______

Last TB Test ______
Last eye exam ______
Last dental exam ______
Last Flu Shot ______
Last colonoscopy ______

Last PSA test (men) ______
Last Mammogram ______
Last PAP (women) ______
LMP ______ Flow: Light / Med / Heavy
Are you pregnant? ______ Number of children ______

FAMILY HISTORY:

If a family member has or has had any of the following problems, check the appropriate box and list the family member:

M=Mother F=Father S=Sibling GM=Grandmother GF=Grandfather A=Aunt U=Uncle

☐ ______ Deafness
☐ ______ Allergies
☐ ______ Drug Allergies
☐ ______ Asthma
☐ ______ Eczema
☐ ______ Respiratory infections
☐ ______ Eye or visual problems
☐ ______ Ear infections / tubes
☐ ______ Tuberculosis
☐ ______ Liver disease

☐ ______ Immunity problems / HIV
☐ ______ High cholesterol
☐ ______ High blood pressure before 50 yrs
☐ ______ Heart attack / stroke before 50 yrs
☐ ______ Other heart problems
☐ ______ Anemia / Blood disorders
☐ ______ Diabetes before 50 yrs
☐ ______ Thyroid or other endocrine problems
☐ ______ Obesity
☐ ______ Bladder / Kidney

☐ ______ Stomach / GI
☐ ______ Cancer
☐ ______ Epilepsy or convulsions
☐ ______ Hereditary problems
☐ ______ Learning problems / Attention Span
☐ ______ Emotional / Behavioral
☐ ______ Mental illness
☐ ______ Mental retardation
☐ ______ Drug / Alcohol abuse
☐ ______ Other

PATIENT NAME: DATE OF BIRTH:

SURGICAL HISTORY: ***Please list all surgeries and include dates***

☐Appendix ________ ☐Tubal ligation ________ ☐Elbow scope ________ ☐Pacemaker (type)________

☐Tonsils________ ☐Hysterectomy (partial) ________ ☐Shoulder scope________ ☐Stents________

☐Gallbladder ________ ☐Hysterectomy (complete) ________ ☐Knee scope________ ☐Metal implants________

☐Vasectomy________ ☐Joint replacement________ ☐Other scope ________ ☐Any implants? ________

☐Other:________ which joint________ ________ ________

☐Other:________ ☐Other:________ ☐Other:________ ☐Other: ________

DRUG ALLERGIES? ☐Yes ☐No ***If yes, please check:*** ☐Aspirin ☐Codeine ☐Tetracycline ☐Mycins ☐Sulfa ☐Morphine

☐**Other: Please list:** ________

LIFESTYLE: ***If sexually active, how many lifetime partners?________*** ***Any history of STD's______ type?________***

Do you currently smoke: ☐cigarettes ______packs per day ____# of yrs ☐cigars ☐pipes ☐Use chewing tobacco or snuff?

If you are a smoker, are you aware of all the health hazards associated with smoking? ☐Yes ☐No

Would you like to participate in a smoking cessation program? ☐Yes ☐No

How many drinks of alcoholic beverages do you have in a typical week? (write number next to drink)

______Bottles or cans of beer (12oz) ______Glasses of wine (6 oz)

______Wine coolers (12 oz) ______Mixed drinks or shots of liquor (1.5 oz)

Drug use: ☐Marijuana ☐Speed / amphetamines ☐Heroin

☐Cocaine / Crack ☐Prescription drugs ☐Other

Do you drink caffeine / coffee? ☐No ☐Yes, please list type and amount ________

Do you exercise regularly? ☐No ☐Yes, please list type and amount ________

ADVANCE DIRECTIVES:

Do you have an Advanced Directive, i.e., written instructions for your family and health care provider in the event that you cannot make a decision yourself about your care? ☐Yes ☐No

Would you like information on Advance Directives? ☐Yes ☐No

SAFETY: COMMENTS:

Do you buckle your safety belt when driving or riding in a motor vehicle? ☐Yes ☐No ________

Do you wear a helmet when riding a bicycle, motorcycle, etc. ? ☐Yes ☐No ________

Do you child-proof your home for poison and electrical hazards? ☐Yes ☐No ________

Do you have current & operational smoke detectors and carbon monixide detectors ☐Yes ☐No ________

Do you have a First-Aid Kit in your home? ☐Yes ☐No ________

Has your First-Aid Kit been checked for outdate supplies? ☐Yes ☐No ________

Do you use eye & ear protection when using potentially harmful agents? ☐Yes ☐No ________

Do you take safety precautions with firearms in the home? ☐Yes ☐No ________

Do you feel safe at home? ☐Yes ☐No ________

Has anyone ever: -hit you? ☐Yes ☐No -insulted you or put you down? ☐Yes ☐No ________

-threatened you? ☐Yes ☐No -forced sex upon you? ☐Yes ☐No ________

If you answered "yes" to any part of the question above, would you like help dealing with this situation? ☐Yes ☐No