

Patient Name _____ Age _____ Birthday _____

Date of last physical examination _____ M.D. _____

What is your reason for this visit? _____

E-mail address for our patient newsletters _____

Symptoms

Check symptoms you currently have or have had in the past year.

GENERAL

- 0 CHILLS
- 0 DEPRESSION
- 0 DISSINESS
- 0 FAINTING
- 0 FEVER
- 0 FORGETFULNESS
- 0 HEADACHES
- 0 LOSS OF SLEEP
- 0 LOSS OF WEIGHT
- 0 NERVOUSNESS
- 0 NUMBNESS
- 0 SWEATS

MUSCLE/JOINT/BONE

PAIN ,WEAKNESS, NUMBNESS IN,

- 0 ARMS
- 0 BACK
- 0 FEET
- 0 HANDS
- 0 HIPS
- 0 LEGS
- 0 NECK
- 0 SHOULDERS

WOMEN ONLY

- 0 ABNORMAL PAP SMEAR
- 0 BLEEDING BETWEEN PERIODS
- 0 BREAST LUMP
- 0 EXTREME MENSTRUAL PAIN
- 0 HOT FLASHES
- 0 OTHER

GASTROINTESTINAL

- 0 APPETITE POOR
- 0 BLOATING
- 0 BOWEL CHANGES
- 0 CONSTIPATION
- 0 DIARRHEA
- 0 EXCESSIVE THIRST
- 0 EXCESSIVE HUNGER
- 0 GAS
- 0 HEMORRHOIDS
- 0 INDIGESTION
- 0 NAUSEA
- 0 RECTAL BLEEDING
- 0 STOMACH PAIN
- 0 VOMITING
- 0 VOMITING BLOOD

EYES, EARS, AND THROAT

- 0 BLURRED VISION
- 0 DIFFICULTY SWALLOWING
- 0 DOUBLE VISION
- 0 EARACHE
- 0 EAR DISCHARGE
- 0 HAY FEVER
- 0 VISION-FLASHES

GENITO-URINARY

- 0 BLOOD IN URINE
- 0 FREQUENT URINATION
- 0 LACK OF BLADDER CONTROL
- 0 PAINFUL URINATION

CARDIOVASCULAR

- 0 CHEST PAIN
- 0 HIGH BLOOD PRESSURE
- 0 IRREGULAR HEART BEAT
- 0 LOW BLOOD PRESSURE
- 0 POOR CIRCULATION
- 0 RAPID HEART BEAT
- 0 SWELLING OF ANKLES
- 0 VARICOSE VEINS

Date of last menstrual period _____

Are you pregnant? _____

Number of children _____

Date of bone density testing (if applicable) _____

Medications:

List medications you are currently taking

Allergies:

Supplements:

Conditions:

Check symptoms you currently have or have had in the past year.

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> AIDS | <input type="checkbox"/> CHEM. DEPENDENCY | <input type="checkbox"/> HIGH CHOLESTEROL | <input type="checkbox"/> PROSTATE PROBLEMS |
| <input type="checkbox"/> ALCOHOLISM | <input type="checkbox"/> CHICKEN POX | <input type="checkbox"/> HIV POSITIVE | <input type="checkbox"/> PSYCHIATRIC CARE |
| <input type="checkbox"/> ANEMIA | <input type="checkbox"/> DIABETES | <input type="checkbox"/> KIDNEY DISEASE | <input type="checkbox"/> RHEUMATIC FEVER |
| <input type="checkbox"/> ANOREXIA | <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> LIVER DISEASE | <input type="checkbox"/> SCARLET FEVER |
| <input type="checkbox"/> APPENDICITIS | <input type="checkbox"/> EPILEPSY | <input type="checkbox"/> MEASLES | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> GLAUCOMA | <input type="checkbox"/> MIGRAINE HEADACHES | <input type="checkbox"/> SUICIDE ATTEMPT |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> GOITER | <input type="checkbox"/> MISCARRIAGE | <input type="checkbox"/> THYROID PROBLEMS |
| <input type="checkbox"/> BLEEDING DISORDERS | <input type="checkbox"/> GONORRHEA | <input type="checkbox"/> MONONUCLEOSIS | <input type="checkbox"/> TONSILITIS |
| <input type="checkbox"/> BREAST LUMP | <input type="checkbox"/> GOUT | <input type="checkbox"/> MULTIPLE SCLEROSIS | <input type="checkbox"/> TUBERCULOSIS |
| <input type="checkbox"/> BRONCHITIS | <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> MUMPS | <input type="checkbox"/> THYROID FEVER |
| <input type="checkbox"/> BULIMIA | <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> PACEMAKER | <input type="checkbox"/> ULCERS |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> HERNIA | <input type="checkbox"/> PNEUMONIA | <input type="checkbox"/> VENERAL DISEASE |
| <input type="checkbox"/> CATARACTS | <input type="checkbox"/> HERPES | <input type="checkbox"/> POLIO | |

Family History:

	AGE	HEALTH STATUS	AGE AT DEATH	CAUSE OF DEATH
FATHER	_____	_____	_____	_____
MOTHER	_____	_____	_____	_____
BROTHER	_____	_____	_____	_____
BROTHER	_____	_____	_____	_____
BROTHER	_____	_____	_____	_____
SISTER	_____	_____	_____	_____
SISTER	_____	_____	_____	_____
SISTER	_____	_____	_____	_____

CHECK IF YOUR BLOOD RELATIVES HAVE/HAD THE FOLLOWING:

- | | | |
|--------------------------|-----------------------|------------|
| <input type="checkbox"/> | ARTHRITIS, GOUT | WHOM _____ |
| <input type="checkbox"/> | ASTHMA, HAY FEVER | WHOM _____ |
| <input type="checkbox"/> | CANCER | WHOM _____ |
| <input type="checkbox"/> | DIABETES | WHOM _____ |
| <input type="checkbox"/> | HEART DISEASE, STROKE | WHOM _____ |
| <input type="checkbox"/> | HIGH BLOOD PRESSURE | WHOM _____ |
| <input type="checkbox"/> | KIDNEY DISEASE | WHOM _____ |
| <input type="checkbox"/> | TUBERCULOSIS | WHOM _____ |

Hospitalizations/Surgeries

YEAR	HOSPITAL	REASON
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Pregnancies

BIRTH YEAR	COMPLICATION (IF ANY)
_____	_____
_____	_____
_____	_____
_____	_____

Occupational:

Check, IF your work exposes you to the following:

STRESS HEAVY LIFTING REPETITIVE MOVEMENTS HAZARDOUS SUBSTANCES

OTHER _____ OCCUPATION _____

Accidents/Illnesses/Injuries:

DATE _____ OUTCOME _____

DATE _____ OUTCOME _____

DATE _____ OUTCOME _____

Health Habits: Check which substances you use and describe how much you use:

___ CAFFEINE _____ ___ TOBACCO _____

___ DRUGS _____ ___ OTHER _____

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 staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

Reviewed by: _____ Date _____