

Name: \_\_\_\_\_ Birthdate: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Referring Doctor: \_\_\_\_\_

BRIEFLY DESCRIBE THE REASON FOR YOUR VISIT:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Do you have any recent x-ray's to be reviewed? Y / N

If so, what type? \_\_\_\_\_ Where done? \_\_\_\_\_

**CHECK IF YOU HAD ANY OF THE FOLLOWING SYMPTOMS IN THE PAST YEAR:**

**General**

- Chills
- Depression
- Dizziness
- Fainting
- Fatigue
- Fever
- Forgetful
- Headache
- Loss of Sleep
- Nervousness
- Sweats
- Weight Loss

**Muscle/Joint/Bone**

- Back Pain
- Cold Extremities
- Difficulty Walking
- Joint stiffness/swelling

**Pain/weakness/numbness in:**

- Arms     Hips
- Back     Legs
- Feet     Neck
- Hands     Shoulders

**Genito-Urinary**

- Blood in Urine
- Frequent Urination
- Kidney Stones
- Lack of bladder control
- Painful Urination

**Gastrointestinal**

- Abdominal Pain
- Poor Appetite
- Bloating
- Bowel Changes
- Constipation
- Diarrhea
- Excessive Hunger
- Excessive Thirst
- Gas
- Hemorrhoids
- Rectal Bleeding
- Stomach Pain
- Vomiting
- Vomiting Blood
- Ulcer Disease

**Cardiovascular**

- Chest Pain
- High Blood Pressure
- Irregular Heart Beat
- Low Blood Pressure
- Poor Circulation
- Rapid Heart Beat
- Swelling of ankles
- Varicose Veins

**Respiratory**

- Chronic Cough
- Shortness of Breath
- Spitting up Blood
- Wheezing

**Eye/Ear/Nose/Throat**

- Bad Breath
- Bleeding Gums
- Blurred Vision
- Change in Voice
- Crossed Eyes
- Difficulty Swallowing
- Double Vision
- Earache
- Ear Discharge
- Hay Fever
- Hoarseness
- Loss of Hearing
- Mouth Sores
- Nosebleeds
- Ringing in Ears
- Sinus Problems
- Swollen Glands in Neck
- Visual Flashes
- Visual Halos

**Skin**

- Bruise Easily
- Change in hair or nails
- Change in moles
- Change in skin color
- Hives
- Itching
- Rash
- Scars
- Sore that won't heal

**Men Only**

- Breast Lump
- Erection difficulties
- Lump in testicles
- Penis discharge
- Sore on penis
- Testicular pain

**Women Only**

- Abnormal Pap Smear
- Bleeding between periods
- Breast Lump
- Extreme menstrual pain
- Hot Flashes
- Irregular menstrual period
- Nipple discharge
- Vaginal discharge

**Neurological**

- Convulsions or Seizures
- Head Injury
- Paralysis
- Stroke
- Tingling or Numbness
- Tremors

**Endocrine**

- Change hat or glove size
- Excessive thirst
- Excessive urination
- Hot or cold intolerance
- Skin becoming dryer
- Other

**WOMEN:**

Date of Last Menstrual Period: \_\_\_\_\_ Age when menstrual periods started: \_\_\_\_\_

Do you still have regular menstrual periods: Y / N If no, how old were you when they stopped: \_\_\_\_\_

How many times have you been pregnant? \_\_\_\_\_ How many children do you have? \_\_\_\_\_

Menstrual Problems? Y/N If yes, please describe:

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Date of last Pelvic Exam: \_\_\_\_\_ Do you perform a Self Breast Exam: Y / N

**PLEASE LIST ANY ALLERGIES THAT YOU HAVE:**

None

Allergy to:

Reaction:

_____	_____
_____	_____
_____	_____
_____	_____

**FAMILY HISTORY:**

Any history of cancer in your family? Y / N

If yes: RELATION TYPE OF CANCER

_____	_____
_____	_____
_____	_____

Any other family medical problems? Y / N

If yes, please describe:

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**CHECK IF YOU HAVE EVER HAD ANY OF THE FOLLOWING CONDITIONS:**

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> AIDS                | <input type="checkbox"/> Chicken Pox         | <input type="checkbox"/> HIV Positive          | <input type="checkbox"/> Polio              |
| <input type="checkbox"/> Alcoholism          | <input type="checkbox"/> Diabetes            | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Prostate Problems  |
| <input type="checkbox"/> Anemia              | <input type="checkbox"/> Emphysema           | <input type="checkbox"/> Kidney Stones         | <input type="checkbox"/> Psychiatric Care   |
| <input type="checkbox"/> Anorexia            | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Leg Ulcers            | <input type="checkbox"/> Rheumatic Fever    |
| <input type="checkbox"/> Appendicitis        | <input type="checkbox"/> Glaucoma            | <input type="checkbox"/> Liver Disease         | <input type="checkbox"/> Scarlet Fever      |
| <input type="checkbox"/> Arthritis           | <input type="checkbox"/> Goiter              | <input type="checkbox"/> Measles               | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Gonorrhoea          | <input type="checkbox"/> Migraine Headaches    | <input type="checkbox"/> Stomach Ulcers     |
| <input type="checkbox"/> Bleeding Disorders  | <input type="checkbox"/> Gout                | <input type="checkbox"/> Miscarriage           | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Blood Clots         | <input type="checkbox"/> Heart Attack        | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Suicide Attempt    |
| <input type="checkbox"/> Breast Lump         | <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Mononucleosis         | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Bronchitis          | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Multiple Sclerosis    | <input type="checkbox"/> Tonsillitis        |
| <input type="checkbox"/> Bulimia             | <input type="checkbox"/> Hernia              | <input type="checkbox"/> Mumps                 | <input type="checkbox"/> Transfusion        |
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Herpes              | <input type="checkbox"/> Pacemaker             | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Phlebitis             | <input type="checkbox"/> Vaginal Infections |
| <input type="checkbox"/> Chemical Dependency | <input type="checkbox"/> High Cholesterol    | <input type="checkbox"/> Pneumonia             | <input type="checkbox"/> Venereal Disease   |

**PLEASE LIST ANY PREVIOUS SURGERIES:**

<u>PROCEDURE</u>	<u>DATE</u>	<u>REASON</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Have you ever had a colonoscopy? Y / N    If so, when? \_\_\_\_\_**

**SOCIAL**

Marital Status: \_\_\_\_\_Single    \_\_\_\_\_Married    \_\_\_\_\_Divorced    \_\_\_\_\_Widowed

Do you smoke? Y / N

If yes, how many packs/day? \_\_\_\_\_ How many years? \_\_\_\_\_ If quit, how long ago? \_\_\_\_\_

Do you drink alcohol? Y / N

If yes, how much? \_\_\_\_\_

Do you take drugs? Y / N

**MEDICATIONS**

Please list the PRESCRIPTION MEDICATIONS you are currently taking:

<u>NAME/DOSE</u>	<u>FREQUENCY</u>	<u>REASON FOR TAKING</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list the OVER THE COUNTER MEDICATIONS you are taking (including vitamins and herbal supplements):

<u>NAME /DOSE</u>	<u>FREQUENCY</u>	<u>REASON FOR TAKING</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you take any steroids? Y / N

Do you take aspirin daily? Y / N

Do you take any blood thinners? Y / N

Do you take antibiotics for dental procedures? Y / N

PATIENT SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_

PHYSICIAN SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_