



<b>Patient Name</b> (Last, First, Middle Initial):			<b>Date of Birth:</b>	
<b>Injuries:</b> List all significant injuries which you have experienced either in childhood or adult life and provide the approximate year and any complications.				
Injury	Year	Complications	Comments	
<b>Immunizations:</b>		Yes	No	Year
Flu Vaccine				
Pneumonia Vaccine				
Hepatitis A or B ( <i>circle</i> )				
Tetanus				
Pertussis (Whooping Cough)				
MMR (Measles, Mumps, Rubella)				
Varicella (Chicken Pox)				
HPV				
Other: (Specify)				
<b>Allergies:</b> List all drugs or substances to which you are allergic and specify type of reactions, e.g., itching, rash, hives, wheezing, swelling, etc.				
Allergy		Reaction		
<b>Habits:</b>	Yes	No	How much? (per day/per week)	
Cigarettes				
Cigars				
Pipe				
Alcohol				
Drugs (Specify)				
Do you wear seatbelts?				
<b>Medications:</b> 1) List all medications that you take regularly, including over-the-counter medications, herbal treatments, natural supplements and vitamins.				
Name of medication		Amount per day		
Please use a separate piece of paper if needed.				

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2) List all medications which you have taken in the past six (6) months, <b>excluding</b> those listed above.				
<b>C. Family History:</b>				
<b>Relative</b>		<b>Age</b>	<b>State of health (if dead, list cause of death.)</b>	
Father				
Mother				
Brothers	Sisters			
Sons	Daughters			
<b>Illness:</b> Have any relatives had the following illnesses:				
<b>Illness</b>	<b>Yes</b>	<b>No</b>	<b>If yes, what relation?</b>	<b>Comments</b>
Diabetes				
High Blood Pressure				
Heart Disease				
Kidney Disease				
Strokes				
Hardening of the Arteries				
Arthritis or Rheumatism				
Goiter				
Cancer				
Tuberculosis				
Venereal Disease				
Lupus or other Autoimmune				
<b>D. Review of systems:</b> Please check "Yes" or "No" to indicate if you are experiencing the following symptoms. If you are not sure, leave the answer and "Comments" section blank.				
<b>General</b>				
<b>Yes</b>	<b>No</b>	<b>Symptom</b>		<b>Comments</b>
		Fatigue ____ Early Morning ____ Late Afternoon		
		Lack of appetite		
		Excess appetite		
		Weight loss		
		Weight gain		

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<b>General (continued)</b>			
<b>Yes</b>	<b>No</b>	<b>Symptom</b>	<b>Comments</b>
		Chills	
		Fever	
		Night sweats	
		Difficulty sleeping	
<b>Eyes, Ears, Nose, Throat</b>			
<b>Yes</b>	<b>No</b>		<b>Comments</b>
		Decreased ability to see	
		Blurred vision	
		Spots before your eyes	
		Pain in the eyes	
		Infection in the eyes	
		Difficulty hearing	
		Ringing in your ears	
		Pain in your ears	
		Discharge from the ears	
		Nosebleeds	
		Running of the nose	
		Stiffness of the nose	
		Sneezing	
		Post-nasal drip	
		Sinus trouble	
		Hay fever	
		Sore throat	
		Hoarseness	
		Pain in the neck	
		Dental trouble	
		Bleeding gums	
<b>Respiratory</b>			
<b>Yes</b>	<b>No</b>		<b>Comments</b>
		Dry cough	
		Coughing up phlegm	
		Coughing up blood	
		Wheezing	
		Asthma	
		Shortness of breath at rest	
		Shortness of breath with exertion	
		Pain in chest when you cough, sneeze or move	

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<b>Cardiovascular</b>			
<b>Yes</b>	<b>No</b>		<b>Comments</b>
		Chest pain, tightness or squeezing	
		Shortness of breath when lying down	
		Need to sit up to breathe	
		Heart racing	
		Irregular heart beat (palpitations)	
<b>Yes</b>	<b>No</b>		
		Heart murmur	
		Swelling of the legs	
		Varicose veins	
		Leg pain at rest	
		Leg pain with exertion	
		Blue or purple discoloration of hands or feet	
<b>Breasts</b>			
<b>Yes</b>	<b>No</b>		<b>Comments</b>
		Lump	
		Pain	
		Discharge	
<b>Gastrointestinal</b>			
<b>Yes</b>	<b>No</b>		<b>Comments</b>
		Nausea	
		Vomiting	
		Diarrhea	
		Constipation	
		Heartburn	
		Abdominal pain	
		Bright red blood in stools	
		Black, tarry stools	
		Change in bowel habits	
		Food intolerance	
		Need for antacids	
		Hemorrhoids	
<b>Urinary</b>			
<b>Yes</b>	<b>No</b>		<b>Comments</b>
		Urinary Tract Infections	
		Pain or burning on urination	
		Frequent urination during day	

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<b>Urinary (continued)</b>			
<b>Yes</b>	<b>No</b>		<b>Comments</b>
		Frequent urination at night	
		Unusually large volumes of urine	
		Extreme urge to urinate	
		Difficulty starting urinary stream	
		Difficulty stopping urinary stream	
		Kidney stones	
<b>Genital/Reproductive - MALE</b>			
<b>Yes</b>	<b>No</b>		<b>Comments</b>
		Sexually transmitted disease	
		Discharge from penis	
		Testicular pain	
		Lumps in testicles or scrotum	
		Decreased sexual desire	
		Difficulty achieving erection	
<b>Genital/Reproductive - FEMALE</b>			
<b>Yes</b>	<b>No</b>		<b>Comments</b>
		Age of onset of menstrual periods	
		Age when periods stopped (menopause)	
		How far apart are your periods?	
		Is flow normal, heavy, or scanty?	
		Do you ever bleed between periods?	
		Do cramps ever prevent you from performing normal activities?	
		What was the date of your last normal period?	
		What was the date of the period before that?	
		Do you ever have heavy vaginal discharge?	
		What form of birth control do you use?	
		Have you had a venereal disease? If yes, what kind?	
		Does intercourse cause undue pain?	
		Do you have decreased sexual desire?	
		Have you had any vaginal bleeding since menopause?	
		Are you bothered by hot flashes?	
		Are you taking any female hormones?	

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<b>Obstetrical</b>			
	<b>Number</b>	<b>None</b>	<b>Comments</b>
Full-term deliveries			
Miscarriages			
Stillbirths			
<b>Complications:</b>			
High blood pressure			
Toxemia			
Severe hemorrhage			
Children over 9 lbs. birth weight			
Other (specify):			
<b>Musculoskeletal</b>			
<b>Yes</b>	<b>No</b>		<b>Comments</b>
		Painful joints	
		Swelling of any joints	
		Redness of any joints	
		Stiffness of any joints	
		Deformities of the joints or extremities	
		Muscle pain	
		Back pain	
		Pain down the back of the legs	
<b>Endocrine</b>			
<b>Yes</b>	<b>No</b>		<b>Comments</b>
		Goiter	
		Heat intolerance	
		Cold intolerance	
		Trembling hands	
		Change in pitch of voice	
		Increased body hair (face, underarms or pubic)	
		Decreased body hair (face, underarms or pubic)	
		Decrease in breast size	
		Loss of periods (Disregard if from normal menopause.)	
		Increased thirst	
		Increased urination	
		Marked increase in appetite	

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<b>Neurologic/Psychiatric</b>			
<b>Yes</b>	<b>No</b>		<b>Comments</b>
		Nervousness	
		Depression	
		Difficulty going to sleep	
		Early morning awakening	
		Difficulty recalling past events	
		Cloudy thinking or trouble problem-solving	
		Headaches	
		Blackouts	
		Dizziness	
		Double vision	
		Paralysis/weakness of limb(s)	
		Loss of sensation	
		Loss of balance	
		Loss of coordination	
		Difficulty speaking	
<b>Skin</b>			
<b>Yes</b>	<b>No</b>		<b>Comments</b>
		Dryness of skin	
		Itching	
		Rash	
		Change in skin color	
		Change in hair texture	
		Hair loss	
		Nail changes	