

PLEASE PRINT

PATIENT HISTORY

PLEASE PRINT

NAME

GENDER

MARITAL STATUS

BIRTHDATE:

M F

S M W D SEP

OCCUPATION:

Medical History

Please check the appropriate box (Y for Yes, N for No) if you have ever had any of the following items. Please make sure that you have checked a box for each item. Thank you.

	Y	N		Y	N		Y	N
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy spells	<input type="checkbox"/>	<input type="checkbox"/>	German measles	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Fainting spells	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>
Rapid/fluttering heart beat	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	HIV	<input type="checkbox"/>	<input type="checkbox"/>
Irregular pulse	<input type="checkbox"/>	<input type="checkbox"/>	Tremors/hand shaking	<input type="checkbox"/>	<input type="checkbox"/>	Sexually Transmitted Disease:	<input type="checkbox"/>	<input type="checkbox"/>
Swollen ankles	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness	<input type="checkbox"/>	<input type="checkbox"/>	Other Disease(s):	<input type="checkbox"/>	<input type="checkbox"/>
Leg pain – when walking	<input type="checkbox"/>	<input type="checkbox"/>	Numbness/tingling	<input type="checkbox"/>	<input type="checkbox"/>	Alcohol consumption:	<input type="checkbox"/>	<input type="checkbox"/>
Varicose veins/Phlebitis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____ oz. per week		
Cold / Numb feet	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Tobacco: <input type="checkbox"/> Smoke <input type="checkbox"/> Chew <input type="checkbox"/>		
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Bruise easily	<input type="checkbox"/>	<input type="checkbox"/>	_____ cans/cig/day _____ # years		
Pneumonia/Pleurisy	<input type="checkbox"/>	<input type="checkbox"/>	Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>	Caffeine consumption:	<input type="checkbox"/>	<input type="checkbox"/>
Bronchitis/Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Hay fever/Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____ cups daily. Type: _____		
Asthma/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Recurrent rashes	<input type="checkbox"/>	<input type="checkbox"/>	Illegal drug use:	<input type="checkbox"/>	<input type="checkbox"/>
Short of breath – on exertion	<input type="checkbox"/>	<input type="checkbox"/>	Hives	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Short of breath – lying down	<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Last complete physical: _____		
Recent loss of appetite	<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Unknown		
Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	Chronic fatigue	<input type="checkbox"/>	<input type="checkbox"/>	_____		
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Recent weight change	<input type="checkbox"/>	<input type="checkbox"/>	MALES – Please complete:		
Peptic ulcer	<input type="checkbox"/>	<input type="checkbox"/>	Loss _____ lb. Gain _____ lb.			Erectile Difficulty	<input type="checkbox"/>	<input type="checkbox"/>
Persistent nausea/vomiting	<input type="checkbox"/>	<input type="checkbox"/>	Cancer _____			FEMALES – Please complete:		
Chronic abdominal pain	<input type="checkbox"/>	<input type="checkbox"/>	Decreased hearing	<input type="checkbox"/>	<input type="checkbox"/>	Not Menstruating Yet	<input type="checkbox"/>	
Gall bladder trouble	<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Pain / bleeding during or		
Jaundice/Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent ear infections	<input type="checkbox"/>	<input type="checkbox"/>	after sex	<input type="checkbox"/>	<input type="checkbox"/>
Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>	Noticeable vision change	<input type="checkbox"/>	<input type="checkbox"/>	Pain / cramps	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Eye pain	<input type="checkbox"/>	<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	<input type="checkbox"/>
Frequent Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Double or blurred vision	<input type="checkbox"/>	<input type="checkbox"/>	Date of last PAP test _____		
Diverticulosis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent eye infection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Crohn's/Colitis	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nose bleed	<input type="checkbox"/>	<input type="checkbox"/>	Date of last Mammogram _____		
Bloody or tarry stools	<input type="checkbox"/>	<input type="checkbox"/>	Frequent sore throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Normal <input type="checkbox"/> Abnormal		
Hemorrhoids	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Menopause (age) _____		
Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty sleeping or			Age Periods Started _____		
Frequent urine infections	<input type="checkbox"/>	<input type="checkbox"/>	concentrating	<input type="checkbox"/>	<input type="checkbox"/>	Days of flow _____		
Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Days between periods _____		
Kidney stones	<input type="checkbox"/>	<input type="checkbox"/>	Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	Date last period began _____		
Urination (overnight > 2)	<input type="checkbox"/>	<input type="checkbox"/>	Agitation	<input type="checkbox"/>	<input type="checkbox"/>	Current Menstrual Flow:		
Painful urination	<input type="checkbox"/>	<input type="checkbox"/>	Memory loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Regular <input type="checkbox"/> Irregular <input type="checkbox"/> None		
Urination (loss of control)	<input type="checkbox"/>	<input type="checkbox"/>	Moodiness	<input type="checkbox"/>	<input type="checkbox"/>	Number of: Pregnancies _____		
Decreased urine flow/force	<input type="checkbox"/>	<input type="checkbox"/>	Suicidal thoughts	<input type="checkbox"/>	<input type="checkbox"/>	Miscarriages _____		
Urethral discharge	<input type="checkbox"/>	<input type="checkbox"/>	Phobias (fears)	<input type="checkbox"/>	<input type="checkbox"/>	Abortions _____		
Arthritis/Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	Mental illness	<input type="checkbox"/>	<input type="checkbox"/>	Births _____		
Recurrent back pain	<input type="checkbox"/>	<input type="checkbox"/>	Feelings of unworthiness	<input type="checkbox"/>	<input type="checkbox"/>	Birth Control Method _____		
Bone fracture/joint injury	<input type="checkbox"/>	<input type="checkbox"/>	ADHD/ADD	<input type="checkbox"/>	<input type="checkbox"/>			
Gout	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic fever	<input type="checkbox"/>	<input type="checkbox"/>			
Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Scarlet fever	<input type="checkbox"/>	<input type="checkbox"/>			
Foot pain	<input type="checkbox"/>	<input type="checkbox"/>	Chicken pox	<input type="checkbox"/>	<input type="checkbox"/>			
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Polio	<input type="checkbox"/>	<input type="checkbox"/>			
Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>			
Recent hair loss	<input type="checkbox"/>	<input type="checkbox"/>	Red/Hard measles	<input type="checkbox"/>	<input type="checkbox"/>			

PLEASE SIGN



SIGNATURE

DATE

Family History	If any blood relative has suffered any of the following, please check all appropriate boxes.										Immunization History				
<input type="checkbox"/> Unknown Family Hist.											Please give dates for the following immunizations:				
<input type="checkbox"/> No Family Health Problems	Mother	Father	Sister	Brother	Aunt	Uncle	Grandmother	GrandFather			DtaP/DTP	_____	_____	_____	Unknown <input type="checkbox"/>
1) Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	IPV/OPV	_____	_____	_____	<input type="checkbox"/>
2) Migraine	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HIB	_____	_____	_____	<input type="checkbox"/>
3) Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	HepB	_____	_____	_____	<input type="checkbox"/>
4) Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	MMR	_____	_____	_____	<input type="checkbox"/>
5) Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Varicella/ChickenPox	_____	_____	_____	<input type="checkbox"/>
6) Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	_____	_____	_____	<input type="checkbox"/>
7) Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Last Influenza	_____	_____	_____	<input type="checkbox"/>
8) Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Last Tetanus	_____	_____	_____	<input type="checkbox"/>
9) Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you have instructions and someone to represent you if you are unconscious/incompetent? <input type="checkbox"/> Yes <input type="checkbox"/> No				
10) Bleeds easily	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Do you need information about this? <input type="checkbox"/> Yes <input type="checkbox"/> No				
11) Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
12) Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
13) Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
14) Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
15) High blood press.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
16) Lipid disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
17) Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
18) Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
19) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
20) _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					

Exercise	Do you regularly exercise <input type="checkbox"/> Yes <input type="checkbox"/> No	Activity: _____	Times/Week: _____
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Hospital Admissions <i>not including pregnancies</i>	<input type="checkbox"/> None		YEAR	ILLNESS OR OPERATION
	YEAR	ILLNESS OR OPERATION		

LIST ALL MEDICATIONS, VITAMINS & SUPPLEMENTS YOU ARE TAKING, INCLUDING DOSAGES

<input type="checkbox"/> No Medications, Vitamins, or Supplements Taken	
LIST DRUG ALLERGIES <input type="checkbox"/> None Known	LIST ALL OTHER ALLERGIES <input type="checkbox"/> None Known

IS THERE ANYTHING ELSE YOU WANT THE DOCTOR TO KNOW?