

*REASON FOR YOUR VISIT TODAY: _____

Print Name: _____ Today's Date: _____

Date of Birth: ____ / ____ / ____ Age: _____

SOCIAL HISTORY:

WHO DO YOU LIVE WITH? PARENTS SELF SPOUSE CHILDREN ROOMMATE SIGNIFICANT OTHER

MARITAL STATUS: MARRIED SINGLE DIVORCED WIDOWED OTHER

YOUR OCCUPATION: _____

CHILDREN AND AGES _____

DO YOU EXERCISE? NO OCCASIONALLY REGULARLY(4+ times a week)

ALCOHOL QUANTITY? _____ TOBACCO QUANTITY? _____ CAFFEINE QUANTITY? _____

DO YOU REGULARLY USE RECREATIONAL/STREET DRUGS? _____

CURRENT MEDICATIONS W/DOSAGES: _____

LIST ALLERGIES TO MEDICATIONS: _____

Please Check any significant chronic medical problem or serious illness/injuries:

HIGH BLOOD PRESSURE ASTHMA EPILEPSY HEART DISEASE STROKE

HIGH CHOLESTEROL HYPOTHYROIDISM DIABETES OVERWEIGHT/OBESE DEPRESSION

BLEEDING DISORDER KIDNEY DISEASE ARTHRITIS CANCER: type: _____

TUBERCULOSIS OSTEOPOROSIS STROKE _____

*OTHER: _____

HOSPITALIZATIONS/SURGERIES:

YEAR	REASON	HOSPITAL

HAVE YOU EVER HAD A BLOOD TRANSFUSION? YES ____ NO ____ IF YES, WHEN? _____

FAMILY HISTORY:

RELATIONSHIP	AGE	STATE OF HEALTH	AGE at DEATH	MEDICAL PROBLEMS/OR CAUSE OF DEATH
FATHER				
MOTHER				
BROTHERS				
SISTERS				
GRANDPARENTS				

CIRCLE ALL SYMPTOMS YOU PRESENTLY SUFFER:

GENERAL SYMPTOMS:

FATIGUE
 FEVER
 CHILLS
 RECENT WEIGHT GAIN

CARDIOVASCULAR:

CHEST PAIN
 IRREGULAR OR FAST HEART BEAT
 LEG PAIN WITH ACTIVITY

GENITOURINARY:

FREQUENT URINATION
 INABILITY TO HOLD URINE
 BURNING W/URINATION

MUSCULOSKELETAL:

MUSCLE ACHES
 JOINT PAIN _____

HEENT:

HEADACHE
 SINUS PAIN
 VISION PROBLEMS
 MUCOUS DISCHARGE FROM EYES

PULMONARY:

DIFFICULTY BREATHING
 COUGH
 WHEEZING

FEMALE:

VAGINAL PAIN
 BLEEDING BETWEEN PERIODS

NEUROLOGICAL:

DIZZINESS
 LIGHTHEADEDNESS
 SENSORY DISTURBANCES
 MEMORY LAPSE OR LOSS

HEARING LOSS

EARACHE
 RINGING IN EARS
 SORE THROAT

GASTROINTESTINAL:

HEARTBURN
 VOMITTING
 ABDOMINAL PAIN

MALE:

PENILE LESION
 SCROTAL PAIN
 DISCHARGE LUMP

PSYCHOLOGICAL:

ANXIETY
 DEPRESSION
 INSOMNIA

BREAST:

BREAST LUMP
 NIPPLE DISCHARGE
 PAIN IN BREAST

CHANGE IN STOOL

DIARRHEA
 DIFFICULTY SWALLOWING
 CONSTIPATION

ENDOCRINE:

HOT/COLD INTOLERANCE
 HOT FLASHES

SKIN:

ITCHING
 LESIONS
 CHANGE IN MOLES