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Name	Date of Birth	Date
Please describe your reason for seeing the doctor: 		
List all surgical procedures or operations: 	List names of current and recent physicians: 	
List other hospitalizations over the past 5 year: 		
ILLNESS: If you have had any of the following, check the appropriate box. Check S if the illness pertains to you or check R if the illness pertains to a relative in your family.		
☐ S ☐ R Alcoholism	☐ S ☐ R Glaucoma	☐ S ☐ R Cancer, tumor
☐ S ☐ R Anemia	☐ S ☐ R Heart disease	☐ S ☐ R Cancer, prostate
☐ S ☐ R Diabetes	☐ S ☐ R Stroke	☐ S ☐ R Cancer, breast/ovarian
☐ S ☐ R Drug abuse	☐ S ☐ R Eye problems	☐ S ☐ R Cancer, colon
☐ S ☐ R Eczema, hives, rashes	☐ S ☐ R Blood clots, phlebitis	☐ S ☐ R Melanoma
☐ S ☐ R Liver disease, hepatitis	☐ S ☐ R Psychiatric care	☐ S ☐ R Thyroid disease, cancer
☐ S ☐ R Lung disease	☐ S ☐ R High blood pressure	☐ S ☐ R Other:
☐ S ☐ R Epilepsy seizures	☐ S ☐ R Ulcer in stomach or duodenum	☐ S ☐ R Other:
MEDICINES: List all medicines that you are taking with or without a prescription. 		
MEDICINE ALLERGIES: List all medicines that you are allergic to. 		
FAMILY HISTORY: List major illnesses, cause of death or other health problems in each relative category.		
MOTHER		
FATHER		
BROTHERS		
SISTERS		
GRANDPARENTS		
Other "Family" illnesses		

PLEASE ANSWER THE FOLLOWING PERSONAL HEALTH QUESTIONS BY PLACING A ✓ IN EACH BOX THAT APPLIES TO YOU:

HEAD AND NECK	DIGESTIVE	SKIN
☐ frequent headaches	☐ heartburn	☐ skin problems (eg: rash)
☐ neck pain	☐ bloated stomach	☐ itching or burning skin
☐ neck lumps or swelling	☐ stomach pains	☐ bleeds easily – skin tears easily
	☐ nausea	☐ bruises easily
EYES	☐ vomited blood	☐ odd or unusual mole
☐ wear glasses	☐ difficulty swallowing	NEUROLOGICAL
☐ blurry vision	☐ constipation	☐ faintness or light headed
☐ eye pain or itching	☐ loose bowels or diarrhea	☐ numbness or loss of sensation
☐ see double	☐ black or grey stools	☐ convulsions
☐ watering eyes	☐ acid taste in mouth	☐ change in handwriting
☐ eye trouble	☐ pain in rectum	☐ trembles
	☐ rectal bleeding	☐ weakness, falling, dizziness
EARS	URINARY	MOOD
☐ hearing difficulties	☐ night frequency/waking to urinate	☐ confusion
☐ earaches	☐ day frequency	☐ difficulty in making decisions
☐ buzzing or ringing	☐ wets pants or bed	☐ lack of concentration or memory
☐ motion sickness	☐ burning on urination	☐ lonely or depressed
	☐ brown or bloody urine	☐ cries often
MOUTH	☐ difficulty starting urine	☐ hopeless outlook
☐ dental problems	☐ urgency	☐ difficulty relaxing
☐ swelling on gums or jaws	MALE	☐ worries a lot
☐ taste changes	☐ weak urine stream	☐ frightening dreams or thoughts
	☐ burning or discharge	☐ shy or sensitive
NOSE AND THROAT	☐ lumps on testicles	☐ agitation
☐ congested nose	☐ painful testicles	☐ loses temper
☐ running nose	FEMALE	☐ annoyed by little things
☐ sneezing spells	☐ last menstrual period ____ / ____ / ____	☐ work or family problems
☐ head colds	☐ post menopausal	
☐ nose bleeds	☐ hysterectomy	
☐ sore throat	☐ abnormal vaginal bleeding	☐ considered suicide
☐ enlarged tonsils	☐ abnormal last menstrual period	☐ desire psychiatric or counseling help
☐ hoarse voice	☐ age at first period _____	GENERAL
RESPIRATORY	☐ bleeding between periods	☐ gained/lost more than 10 pounds
☐ wheezes or gasps	☐ last mammogram ____ / ____ / ____	☐ tends to be too hot or cold
☐ coughing spells	☐ recent vaginal problem	☐ loss of interest in eating
☐ coughs up phlegm	☐ no monthly breast exam	☐ always hungry
☐ coughed up blood	☐ lump or pain in breasts	☐ more thirsty lately
☐ chest colds	☐ complications with birth control	☐ armpits or groin swelling
☐ hurts to breathe	☐ last Pap test ____ / ____ / ____	☐ exhausted or fatigued
☐ excessive sweating, night sweats	OBSTETRIC HISTORY	☐ sleeping difficulties
CARDIOVASCULAR	☐ number of pregnancies ____	☐ exercises less than 3 times per week
☐ high blood pressure	☐ number of live births ____	☐ cigarettes ☐ cigar/pipe ☐ alcohol use
☐ racing heart	☐ number of pre-mature births ____	☐ don't smoke ☐ smokeless tobacco
☐ chest pains		☐ uses sleeping pills, tranquilizers
☐ dizzy spells	MUSCULOSKELETAL	☐ drives vehicle over 25,000 miles per year
☐ shortness of breath	☐ aching muscles or joints	☐ never ☐ sometimes wear seat belt
☐ extra pillows to breathe	☐ swollen joints	☐ alcohol or drug problem
☐ swollen feet or ankles	☐ back pain	☐ two or more alcoholic drinks per day
☐ leg pain	☐ painful feet	☐ sexual difficulties
☐ heart murmur	☐ handicapped	☐ addiction/drug abuse

Special problems, symptoms or other concerns: