Today's Date: ______________________________

Birth Date: ____________ MRN: __________________

I. Reason for today's visit: ____

____.

II.A. Surgeries and Serious Injuries: Type	Year
1. __________________________________	_______
2. __________________________________	_______
3. __________________________________	_______
4. __________________________________	_______
5. __________________________________	_______

II.B. Serious Illness and Hospitalizations: Type	Year
1. __________________________________	_______
2. __________________________________	_______
3. __________________________________	_______
4. __________________________________	_______
5. __________________________________	_______

III. Past Medical History: (circle positives)

a) High blood pressure, Heart attack, Heart disease, Stroke, Phlebitis, Blocked arteries, Rheumatic Fever.

b) Asthma, Tuberculosis or positive TB skin test, Emphysema, Pneumonia, Allergic rhinitis.

c) Gallstones, Hepatitis, Ulcers, Colon polyps, Diverticulitis.

d) Frequent urinary infections, Kidney stones, other Kidney disease, Prostate problems.

e) Diabetes, High Cholesterol, High Triglycerides, Thyroid disorder.

f) Osteoporosis, Arthritis, Gout.

g) Cancer (including skin cancer) Anemia.

h) Migraine, Psychiatric illness, Glaucoma.

i) Other. (Please describe.)

Periodic Health Screening:

Last: mammogram __________ Pap Smear ___________ Colon exam ________ B/P exam _________

IV. Immunizations: Pneumonia Vaccine 19____ Tetanus 19____ Influenza 19_____

V. Family History

Disease(s)

	Living	Dead	Age	Disease(s):
Mother	☐	☐	☐	________________
Father	☐	☐	☐	________________

Brother(s): Number living ______, ______________________
Number Deceased ______, ______________________

Sister(s): Number living ______, ______________________
Number Deceased ______, ______________________

Have any family members had any of the following diseases? (e.g. maternal aunt)

High blood pressure/Stroke/Diabetes. ____
Heart Attack, Heart Disease. ____
Cancer (Breast, Colon, Other). ____
Hereditary/Genetic disorder, Bleeding disorder. ____

VI. Lifestyle/Social History: (circle those that apply to you)

Marital Status: Single Married (how many times) ________, (how long) _______, (# of children) _______
Divorced _______, Widowed _______.

Last grade completed: Jr. High High School College Post Graduate Other
Current Occupation: ____ Hours/Week _____________
Former Occupation: ____.
Diet (e.g. low salt): ____.
Exercise (type/frequency): ____/__________________.
Hobbies and Interests: ____.
Caffeine on a regular basis? Yes☐ No☐ How many cups/cans per day ________________________________.
Have you ever used tobacco products on a regular basis? Yes ☐ No ☐
Average number of cigarettes/day _______ Smoker for how long? ______ If quit, when? _______________________.
Alcohol intake: None ☐ Occasional ☐ 1-2 Drinks/Day ☐ More Than 2 Drinks/Day ☐
Drugs: None ☐ Rarely ☐ Occasional ☐ Daily☐
Seat Belts: Do you use them? Yes ☐ No ☐ Percent of time _____%.
Do you feel your life is stressful? Yes ☐ No ☐ Why ____.
How many hours of sleep/night ____.

VII. List all Prescription medications that you are currently taking:

Drug Drug Strength Frequency

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____

VIII. List any non-prescription (over-the-counter) medicines that you take regularly: __________________________

____.

IX. List any medications which you cannot take or are Allergic to and Why: ______________________________

____.

X. Systems Review (circle systems that apply to you or fill in the appropriate blank.)

1. **General**: Change in weight of more than 10 lbs. over the past year. Yes ______ No ______
2. **Head**: Severe or frequent headaches, visual problems, or hearing problems.
3. **Respiratory**: Persistent cough shortness of breath, or wheezing.
4. **Cardiovascular**: Chest pain/discomfort, palpitations.
5. **Gastrointestinal**: Pain or difficulty with swallowing, frequent or severe indigestion, abdominal pain. Recent change in bowel habits, chronic diarrhea or constipation. Blood in stools.
6. **Urinary**: Frequent or painful urination, frequent nighttime urination. Bladder leakage, difficulty emptying your bladder, sexual difficulties.
7. **Female/Ob-Gyn**: Last Pap smear or pelvic exam _____________, Age of Menopause ______________. History of abnormal Pap smears, abnormal-vaginal bleeding, recent vaginal discharge. History of estrogen use __________, breast discharge, breast lump(s), and breast pain. Perform self-exams. Yes ______ No ______. Last Mammogram _________. Number of pregnancies ________. Number of deliveries ________.
8. **Musculoskeletal**: Joint pains, chronic or severe back pain.
9. **Skin**: Chronic skin rash, skin lesions that are of concern to you.
10. **Neurological**: Frequent or severe dizziness, numbness or tingling of hands or feet, fainting spells.
11. **Mood**: Frequent or recurrent feelings of depression, nervousness, anxiety, or difficulty sleeping.

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