



**MEDICAL HISTORY**

**MEDICAL HISTORY** Check (✓) symptoms you currently have or have had in the past year. (All information is strictly confidential)

<p><b>GENERAL</b></p> <input type="checkbox"/> Chills <input type="checkbox"/> Depression/Nervousness <input type="checkbox"/> Dizziness/Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<p><b>GASTROINTESTINAL</b></p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood	<p><b>EYE, EAR, NOSE, THROAT</b></p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache/Ear discharge <input type="checkbox"/> Hay fever <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Persistent cough <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <input type="checkbox"/> Vision — Flashes/Halos	<p><b>MEN only</b></p> <input type="checkbox"/> Erection difficulties <input type="checkbox"/> Lump in testicles <input type="checkbox"/> Penis discharge <input type="checkbox"/> Sore on penis <input type="checkbox"/> Other _____
<p><b>MUSCLE/JOINT/BONE</b> Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders	<p><b>CARDIOVASCULAR</b></p> <input type="checkbox"/> Chest pain <input type="checkbox"/> High/Low blood pressure <input type="checkbox"/> Irregular/Rapid heart beat <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swelling in ankles <input type="checkbox"/> Varicose veins	<p><b>SKIN</b></p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching/Rash <input type="checkbox"/> Change in moles <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	<p><b>WOMEN only</b></p> <input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <input type="checkbox"/> Other _____
<p><b>GENITO-URINARY</b></p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination	<p>Check (✓) conditions you have or have had in the past</p> <input type="checkbox"/> AIDS <input type="checkbox"/> Appendicitis <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding Disorders <input type="checkbox"/> Breast Lump <input type="checkbox"/> Cancer <input type="checkbox"/> Cataracts <input type="checkbox"/> Chemical Dependency Describe serious illnesses or operations _____	<input type="checkbox"/> HIV Positive <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Liver Disease <input type="checkbox"/> Measles <input type="checkbox"/> Migraine Headaches <input type="checkbox"/> Multiple Sclerosis <input type="checkbox"/> Mumps <input type="checkbox"/> Pacemaker <input type="checkbox"/> Pneumonia	Date of last menstrual period _____ Date of last Pap Smear _____ Have you had a mammogram? _____ Are you pregnant? _____ Number of children _____ <input type="checkbox"/> Polio <input type="checkbox"/> Prostate Problem <input type="checkbox"/> Rheumatic Fever <input type="checkbox"/> Scarlet Fever <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid Problems <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Ulcers <input type="checkbox"/> Venereal Disease

<b>MEDICATIONS / ALLERGIES</b>	<b>HEALTH HABITS</b>
List medications you are currently taking _____ _____ Pharmacy Name _____ Phone (_____) _____ List allergies to medications or substances _____ _____ _____	Check (✓) which you use and how much: <input type="checkbox"/> Caffeine _____ <input type="checkbox"/> Street Drugs _____ <input type="checkbox"/> Tobacco _____ <input type="checkbox"/> Other _____ Your occupation _____
	Check (✓) if your work exposes you to: <input type="checkbox"/> Stress <input type="checkbox"/> Heavy Lifting <input type="checkbox"/> Hazardous Substances <input type="checkbox"/> Other _____

**FAMILY HISTORY**

Date of last physical examination \_\_\_\_\_

What is your reason for visit? \_\_\_\_\_

	FATHER	Present Health or Cause of Death	MOTHER	Present Health or Cause of Death	SPOUSE	Present Health or Cause of Death
ALIVE	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
DECEASED	<input type="checkbox"/>		<input type="checkbox"/>		<input type="checkbox"/>	
BROTHERS	NO. ALIVE	HEALTH		HOW MANY DECEASED	CAUSE OF DEATH	
SISTERS	NO. ALIVE	HEALTH		HOW MANY DECEASED	CAUSE OF DEATH	
CHILDREN	NO. ALIVE	AGES & HEALTH		HOW MANY DECEASED	AGES & CAUSE OF DEATH	

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

<input type="checkbox"/> Diabetes	<input type="checkbox"/> Cancer	<input type="checkbox"/> Bleeding tendency	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Heart disease	<input type="checkbox"/> Stroke	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Nervous illness	<input type="checkbox"/> Allergy
			<input type="checkbox"/> Other	