

BRIEF HISTORY

Last name:	First:	Sex:	DOB:
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What are you being seen for today?

PAST MEDICAL HISTORY

Check (✓) if you have ever had any of the following:

<input type="checkbox"/> AIDS <input type="checkbox"/> Abdominal bleeding <input type="checkbox"/> Accidents <input type="checkbox"/> Alcoholism <input type="checkbox"/> Allergies/hayfever <input type="checkbox"/> Anemia <input type="checkbox"/> Arthritis <input type="checkbox"/> Asthma <input type="checkbox"/> Bleeding problems <input type="checkbox"/> Blood clots <input type="checkbox"/> Breast lump <input type="checkbox"/> Broken bones <input type="checkbox"/> Bronchitis <input type="checkbox"/> Cancer <input type="checkbox"/> Chest pain/tightness <input type="checkbox"/> Cataracts <input type="checkbox"/> Depression	<input type="checkbox"/> Chicken Pox <input type="checkbox"/> Diabetes <input type="checkbox"/> Diverticulosis <input type="checkbox"/> Emphysema <input type="checkbox"/> Epilepsy <input type="checkbox"/> Gallstones <input type="checkbox"/> Glaucoma <input type="checkbox"/> Gout <input type="checkbox"/> Hearing trouble <input type="checkbox"/> Heart disease <input type="checkbox"/> Heart murmur <input type="checkbox"/> Heart trouble/attack <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hepatitis <input type="checkbox"/> Hernia <input type="checkbox"/> High blood pressure <input type="checkbox"/> High cholesterol	<input type="checkbox"/> HIV positive <input type="checkbox"/> Kidney disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Liver disease <input type="checkbox"/> Lung problems <input type="checkbox"/> Measles <input type="checkbox"/> Mental illness <input type="checkbox"/> Migraine headaches <input type="checkbox"/> Mumps <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Pacemaker <input type="checkbox"/> Peptic ulcers <input type="checkbox"/> Pneumonia <input type="checkbox"/> Polio <input type="checkbox"/> Prostate problems <input type="checkbox"/> Psychiatric Care <input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Shortness of breath <input type="checkbox"/> STDs <input type="checkbox"/> Stroke <input type="checkbox"/> Thyroid problem <input type="checkbox"/> Tonsilitis <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Typhoid fever <input type="checkbox"/> Ulcers <input type="checkbox"/> Urinary tract infections <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Varicose veins <input type="checkbox"/> Venereal disease <input type="checkbox"/> Vision trouble <input type="checkbox"/> Yellow jaundice
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PAST SURGICAL HISTORY <input type="checkbox"/> None
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Year	Name of Operation	Location/Surgeon	Complications

FAMILY HISTORY

Relation	Age	Diseases/Illnesses/Cause of death	Has any blood relatives had:	✓	Relationship to you
Father			Arthritis, Gout		
Mother			Asthma, Hay Fever		
Brothers			Cancer		
			Chemical Dependency		
			Diabetes		
			Gallbladder Disease		
			Heart Disease, Strokes		
Sisters			High Blood Pressure		
			Kidney Disease		
			Tuberculosis		
			Varicose Veins		
			Other:		

SOCIAL HISTORY			
Marital Status:	Children:	Occupation:	
Do you now use tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	# per day ___ / Years: ___	Type:
Have you ever used tobacco?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yrs Quit ___	Type:
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	# per day ___ / Years: ___	Type:
Have you ever used alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Yrs Quit ___	Type:

MEDICATIONS <input type="checkbox"/> NONE		
Please list ALL medications, vitamins, suppliments:		
Medication	Dose / Frequency	Who prescribed?

ALLERGIES <input type="checkbox"/> None

REVIEW OF SYSTEMS			
Check (✓) symptoms you currently have or have had in the past year.			
GENERAL	GASTROINTESTINAL	EYE, EAR, NOSE, THROAT	MEN only
<input type="checkbox"/> Chills <input type="checkbox"/> Depression <input type="checkbox"/> Dizziness <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Fatigue <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of Sleep <input type="checkbox"/> Loss of Weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Numbness <input type="checkbox"/> Sweats	<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 hunger <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	<input type="checkbox"/> Bleeding gums <input type="checkbox"/> Blurred vision <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Double vision <input type="checkbox"/> Earache <input type="checkbox"/> 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 <input type="checkbox"/> Vision - Halos	<input type="checkbox"/> Breast lump <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:
MUSCLE/JOINT/BONE Pain, weakness, numbness in: <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	CARDIOVASCULAR <input type="checkbox"/> Chest pain <input type="checkbox"/> High blood pressure <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid hearth beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins	SKIN <input type="checkbox"/> Bruise easily <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Change in moles <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore that won't heal	WOMEN only <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:
			Date of last period:
			Date of last Pap:
			Have you had a mammogram?
			When:
			Where:
			Are you pregnant?

To the best of my knowledge, the above information is true and accurate.

Patient Signature: _____ Date: _____