

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex \_\_\_\_\_ Date \_\_\_\_\_

Who referred you to our office? \_\_\_\_\_

Other Physicians you see: \_\_\_\_\_

Occupation: \_\_\_\_\_ Place of Employment: \_\_\_\_\_

 Marital Status:  Single  Married  Separated  Divorced  Widowed Number of Children: \_\_\_\_\_

**REASON FOR TODAY'S VISIT:** \_\_\_\_\_

 Have you ever been treated for this problem before?  YES  NO

If yes, please give details: \_\_\_\_\_

**PREFERRED PHARMACY AND FAX NUMBER:** \_\_\_\_\_

**ALLERGIES** *List all known allergies and reactions:* \_\_\_\_\_

**MEDICATIONS**
*List all current medications, prescription and nonprescription (EXAMPLE: ASPRIN, HERBALS, VITAMINS):*

Medication	Dose	Frequency	Start Date

**MEN ONLY:**

	YES	Date		YES	Date		YES	Date
Prostate Problems			Prostate Cancer			Cancer of the Testicles		

**WOMEN ONLY:**

	YES	Date		YES	Date		YES	Date
Uterine Cancer			Cervical Cancer			Ovarian Cancer		
Abnormal Pap Smear								

Pregnancies:	Deliveries:	Miscarriages:	Abortions:
Method of Birth Control if Applicable:	Date of Last Menstrual Period:	Could you be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No	

**MEDICAL HISTORY** (Check all that apply)

	YES	Date		YES	Date		YES	Date
Hypertension (High Blood Pressure)			TB (Tuberculosis)			Other Arthritis		
Stroke			Pneumonia			Gout		
Seizures			Emphysema (COPD) or Chronic Bronchitis			Osteoporosis/osteopenia		
Migraines			Heart Abnormalities			Skin disease		
Anemia			Congestive Heart Failure			Phlebitis/blood clots		
Lung cancer			Myocardial Infarction (Heart Attack)			Anemia		
Breast cancer			Mitral Valve Disease			Bleeding disorder		
Colon cancer			High Cholesterol			Depression		
Skin cancer			Coronary Artery Disease			Anxiety		
Other cancer: _____			Psychiatric			Chicken Pox		
Hyperthyroid			Heart Murmur			Measles		
Hypothyroid			Heart Valve Disease			Mumps		
Diabetes			Heart Palpitations or arrhythmias			Infectious Mono		
Stomach or Peptic Ulcer			Pulmonary fibrosis			Allergies/Hay fever		
Kidney Disease			Any other lung disease not mentioned			Hives or Eczema		
Sleep Apnea			Hiatal hernia/GERD			Blood Transfusion		
Liver Disease			Gallstones			Bladder Infections		
Hepatitis			Pancreatitis			Hemorrhoids		
AIDS/HIV			Colitis (not spastic colon)			Hernia		
Sexually Transmitted Disease			Spastic colon or irritable bowel			Back Problems		
Rheumatic Fever			Kidney stones			Other: _____		
Cataract			Kidney infections			Other: _____		
Glaucoma			Rheumatoid arthritis			Other: _____		
Asthma			Osteoarthritis			Other: _____		

**SURGICAL HISTORY**

Check all that apply.

	YES	Date		YES	Date
Cholecystectomy (Gallbladder)			Knee Replacement		
Appendectomy			Hernia Repair		
Tonsillectomy			Pacemaker		
Hysterectomy			Other: _____		
Mastectomy			Other: _____		
Hip Replacement			Other: _____		

Please list as best you can, any times that you have been hospitalized:

Example: 1985 Presbyterian Hospital of Dallas      Pneumonia

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Other Medical History: \_\_\_\_\_

**FAMILY HISTORY**

Please indicate in the spaces below any family members with a history of: diabetes, heart disease, cancer, emphysema, kidney disease, asthma, bleeding tendencies, anemia, epilepsy, glaucoma, high blood pressure, gout, arthritis, ulcer, stroke, nervous breakdown, gall bladder disease. .

Family Member	Age if Living	Health Problems	Age at Time of Death	Cause
Father				
Paternal Grandfather				
Paternal Grandmother				
Mother				
Maternal Grandfather				
Maternal Grandmother				
Brothers (How many in all? _____)				
Sisters (How many in all? _____)				
Sons (How many in all? _____)				
Daughters (How many in all? _____)				
Other family members				

**SOCIAL HISTORY**

Check all that apply.

Your Personal Habits: Do you?	YES	NO	Date Quit	If Yes, how much/how often?
Smoke				
Drink Alcohol				
Use recreational/Intravenous street drugs				

Do you exercise on a regular basis?  Yes  No  
 If so, how much and how often? \_\_\_\_\_

Do you drink caffeine?  Yes  No  
 If so, how much and how often? \_\_\_\_\_

Do you always use your seatbelt when you drive?  Yes  No

**HEALTH MANAGEMENT:**

Please indicate when you last had each of the following exams and if the results were normal /abnormal:

	Date	Normal	Abnormal		Date	Normal	Abnormal
Dental				Bone Density Test/DEXA			
Ophthalmology				Mammogram (female)			
Stress Test				Pelvic/Pap Smear (female)			
Colonoscopy (over age 50)				Breast exam (female)			
Stool test for blood				PSA Exam (male)			
Chest X-ray				Rectal/Prostate Exam (male)			
Tuberculosis skin test (PPD)				Tetanus Shot			
Pneumonia Shot				Flu Shot			
Hepatitis A & B				Shingles Shot			
Gardasil Shot(s) (female)				Other: _____			

## SYSTEM REVIEW

**Instructions: Please circle any of the following that apply to your RECENT health.**

**Constitution**

Fever  
Chills  
Weight Loss  
Malaise/Fatigue  
Diaphoresis (sweating)  
Weakness

**Skin**

Rash  
Itching

**HENT**

Headaches  
Hearing Loss  
Tinnitus (ringing in ears)  
Ear pain  
Ear discharge  
Nosebleeds  
Congestion  
Stridor  
Sore Throat

**Eyes**

Blurred vision  
Double vision  
Photophobia (light sensitivity)  
Eye pain  
Eye discharge  
Eye redness

**Cardiovascular**

Chest pain  
Palpitations (fast heart beat)  
Orthopnea (shortness of breath when laying flat)  
Claudication (calf pain w/ walking)  
Leg swelling  
PND (waking up w/shortness of breath)

**Respiratory**

Cough  
Hemoptysis (coughing up blood)  
Sputum production  
Shortness of breath  
Wheezing

**Gastrointestinal**

Heart Burn  
Nausea  
Vomiting  
Abdominal pain  
Diarrhea  
Constipation  
Blood in stool  
Melena (black sticky stool)

**Genitourinary**

Dysuria (pain w/urination)  
Urgency  
Frequency  
Hematuria (Blood in urine)

Flank pain

**Musculoskeletal**

Myalgias (Muscle Pains)  
Neck Pain  
Back Pain  
Joint Pain  
Falls

**Endo/Heme/Allergy**

Easy bruise/bleed  
Environ. Allergies  
Polydipsia (excessive thirst)

**Neurologic**

Dizziness  
Tingling  
Tremor  
Sensory change  
Speech change  
Focal weakness  
Seizures  
LOC (passing out)

**Psychiatric**

Depression  
Suicidal Ideas  
Substance abuse  
Hallucinations  
Nervous/Anxious  
Insomnia  
Memory loss

**I have read all of the above and I agree that all UNMARKED responses are NOT symptoms that apply to my recent health.**

Please Sign: \_\_\_\_\_

Date: \_\_\_\_\_