Name: _____ **Age:** _____ **Marital Status:** M S W D

Date of Birth: _____

Problem or Present Illness: _____

Past Medical History: **(Check Items You Have or Have Had)**

o ADD	o HEART ATTACK (acute myocardial infarction)
o ADHD	o HEMORRHOIDS
o ANEMIA	o HEPATITIS
o ARTHRITIS	o HIGH BLOOD PRESSURE (hypertension)
o ASTHMA	o HIGH CHOLESTEROL
o CANCER	o IRREGULAR HEART BEAT (palpitations)
o COLITIS	o JAUNDICE
o COLON POLYPS	o KIDNEY STONES (urinary calculus)
o CORONARY ARTERY DISEASE	o MITRAL VALVE DISORDER
o DEPRESSION	o NERVOUS BREAKDOWN
o DIABETES MELLITUS, TYPE I	o PNEUMONIA
o DIABETES MELLITUS, TYPE II	o RHEUMATIC FEVER
o EMPHYSEMA	o SEIZURES
o EPILEPSY	o STOMACH ULCER
o ESSENTIAL HYPERTENSION	o THYROID DISORDER
o GALLSTONES (cholecystitis)	o TUBERCULOSIS
o GLAUCOMA	OTHER: _____
o GERD	
o HEARING LOSS	

Past Surgical History:

HOSPITAL: _____ DATE: _____
HOSPITAL: _____ DATE: _____
HOSPITAL: _____ DATE: _____
HOSPITAL: _____ DATE: _____
SURGERIES: _____ DATE: _____
SURGERIES: _____ DATE: _____
SURGERIES: _____ DATE: _____
SURGERIES: _____ DATE: _____

Medication List:

_____
_____
_____
_____
_____

Allergy List:

ENVIRONMENTAL: _____
FOOD: _____
MEDICATIONS: _____

Family Medical History: **(Please Specify on Grandparents if Paternal or Maternal)**

BROTHERS DECEASED AGE: _____ REASON: _____
BROTHERS LIVING _____
CHILDREN DECEASED AGE: _____ REASON: _____
CHILDREN LIVING _____
FATHER DECEASED AGE: _____ REASON: _____
FATHER LIVING _____

MOTHER DECEASED	AGE: _____REASON:_____
MOTHER LIVING	_____
SISTERS DECEASED	AGE: _____ REASON: _____
SISTERS LIVING	_____
FAMILY HISTORY OF ALZHEIMER'S	RELATIONSHIP: _____
FAMILY HISTORY OF ARTHRITIS	RELATIONSHIP: _____
FAMILY HISTORY OF CANCER	RELATIONSHIP: _____
FAMILY HISTORY OF DIABETES MELLITUS	RELATIONSHIP: _____
FAMILY HISTORY OF HEART ATTACK	RELATIONSHIP: _____
FAMILY HISTORY OF HEART DISEASE	RELATIONSHIP: _____
FAMILY HISTORY OF HEPATITIS	RELATIONSHIP: _____
FAMILY HISTORY OF HIGH BLOOD PRESSURE	RELATIONSHIP: _____
FAMILY HISTORY OF STROKE	RELATIONSHIP: _____
FAMILY HISTORY OF TUBERCULOSIS	RELATIONSHIP: _____

Reproductive History:

CYCLE INTERVAL: _____ # DAYS
MENSES DURATION: _____ # DAYS
LAST MENSTRUAL PERIOD: _____
MEMOPAUSE STATUS:
____PREMENOPAUSAL____PERIMENOPAUSAL___POSTMENOPAUSAL
TOTAL NUMBER OF PREGNANCIES_____ NUMBER OF LIVING _____

Social History: (PLEASE CIRCLE)

ALCOHOL: NEVER CURRENT FORMER ____DRINKS PER DAY
ILLEGAL DRUG ABUSE: NEVER CURRENT FORMER
TOBACCO: NEVER CURRENT FORMER ____PACKS PER DAY

Health Maintenance Record: (Dates of Last Test)

BONE DENSITY: _____	MAMMOGRAM: _____
CHEST X-RAY: _____	PAP SMEAR: _____
COLONOSCOPY: _____	SLEEP STUDY: _____

Review of Systems: (Check Items You Have or Have Had)

o UNEXPLAINED WEIGHT GAIN	o DIFFICULTY SWALLOWING
o UNEXPLAINED WEIGHT LOSS	o ABDOMINAL PAIN
o DOUBLE VISION	o HEARTBURN
o CATARACTS	o FREQUENT NAUSEA/VOMITING
o DECREASED HEARING	o VOMITED BLOOD
o RINGING IN EARS	o FREQUENT DIARRHEA
o RECURRENT NOSE BLEEDS	o PASSED BLOOD FROM RECTUM
o PERSISTENT HOARSENESS	o TARRY STOOLS
o RECURRENT MOUTH ULCERS	o RECTAL PAIN
o EASY GUM BLEEDING	o PAIN WITH URINATION
o FAINTING	o PENILE DISCHARGE
o CHEST PAIN	o VAGINAL DISCHARGE
o HEART PALPITATIONS	o HEADACHE
o SWELLING	o DIZZINESS
o PHLEBITIS	o NUMBNESS
o LEG CRAMPS	o ORTHOPEDIC INJURY
o SHORTNESS OF BREATH	o CHRONIC BACK PAIN
o WHEEZING	o CHRONIC JOINT PAIN
o CHRONIC COUGH	o ENLARGED GLANDS
o COUGHING UP BLOOD	