

## DO YOU HAVE:

### HEAD:

	Yes	No
Visual problems .....		
Eye pain .....		
Ear pain/drainage .....		
Frequent headaches .....		
Sinus problems .....		
Bleeding gums .....		
Frequent sore throats .....		
Dizziness .....		

### CHEST/HEART/LUNGS:

Increased blood pressure .....		
Irregular heartbeat .....		
Shortness of breath .....		
Chest pains .....		
Heart flutter .....		
Persistent cough .....		
Productive cough .....		
Swollen ankles .....		
Decreased exercise tolerance .....		
Asthma/whoezing .....		
History of positive TB skin test .....		
History of ABNORMAL EKG (cardiogram) .....		
History of ABNORMAL chest X-ray .....		
Heart murmur .....		
Elevated cholesterol/triglycerides .....		

### NECK:

Pain in neck .....		
Difficulty swallowing .....		
History of thyroid problem .....		
Change in voice .....		
Radiation therapy to face or neck .....		

### GASTROINTESTINAL:

Change in appetite .....		
Nausea/vomiting .....		
Diarrhea .....		
Constipation .....		
Abdominal pain .....		
Heartburn/indigestion .....		
Change in bowel habits .....		
Blood in stools/tarry stools .....		
Hemorrhoids .....		
Jaundice/hepatitis .....		
Anemia (low blood count) .....		
History of ulcer/peptic disease .....		

### BLADDER/KIDNEY:

Up at least once/night to urinate .....		
Urinating more than 5 times/day .....		
Recurrent bladder infections .....		
Pain when urinating .....		
Blood in urine .....		
Trouble controlling urine .....		
History of kidney stones .....		
Veneral disease .....		

### BONES/JOINTS:

Problems with joints .....		
Gout .....		
Foot trouble/pain .....		
Frequent back pain .....		

### NEURO/MUSCULAR:

	Yes	No
Leg/arm weakness .....		
Fainting .....		
Stroke .....		
Numbness/tingling in extremities .....		
Seizures or epilepsy .....		
Neuritis/sciatica .....		

### ENDOCRINE:

Excessive thirst .....		
Heat/cold intolerance .....		
Fatigue .....		
Change in facial or sexual hair .....		
Low blood sugar .....		
History of sugar in blood or urine .....		
Hot flashes .....		
Change in skin/hair/nails .....		
Weakness .....		
Ever on thyroid medication .....		
Use of dietary iodine (kelp, etc.) .....		
Glucose Tolerance Test .....		
Been treated with cortisone .....		
Been treated with Insulin, Orinase, Dymelor, Tolinase, Diabinese, Diabeta, Micronase, Glucotrol .....		
Weight loss/gain .....		
Adult minimum _____		
Adult maximum _____		

### MALES ONLY:

Lump in testicles .....		
Penis discharge .....		
Sore on penis .....		
Erection difficulties .....		
Breast enlargement/lump .....		
Decrease in body hair/beard .....		
Change in sexual function .....		

### FEMALES ONLY:

Nipple discharge .....		
Breast lump .....		
Vaginal discharge .....		
Hot flashes .....		
Changes in sexual function .....		
Change in periods .....		
Trouble getting pregnant .....		
Menstrual cramps .....		
Ever been on birth control pills .....		
Ever had a pelvic infection .....		
Ever had a mammogram .....		
Use any hormones to get pregnant/ save pregnancy .....		

Age periods started \_\_\_\_\_  
 Date of last Pap \_\_\_\_\_  
 Method of birth control \_\_\_\_\_  
 Number of pregnancies \_\_\_\_\_  
 Number of children \_\_\_\_\_  
 Number of miscarriages/abortions \_\_\_\_\_  
 Age periods stopped \_\_\_\_\_

Patient's Name \_\_\_\_\_

**MEDICATION ALLERGIES:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Date of your last complete physical \_\_\_\_\_ By whom? \_\_\_\_\_

**MEDICATION:** (Name of drug, dosage, frequency taken: include frequently used non-prescription drugs): \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**SURGERIES:**

	Yes	No	If Yes, When?
Appendix .....			
Gall Bladder .....			
Stomach .....			
Colon .....			
Thyroid .....			
Hernia .....			
Breast .....			
Uterus .....			
Ovaries .....			
Prostate .....			
Tonsils/Adenoids ...			

**OTHER HOSPITALIZATIONS:** (when and for what): \_\_\_\_\_

**CHILDHOOD ILLNESSES:**

	Yes	No
1. Have you had Chicken Pox .....		
Rubella (German measles) .....		
Rubeola (10-day, "bad measles") .....		
Mumps .....		
2. Did you have Growth Delay .....		
Birth Defects .....		
Learning Disabilities .....		
3. Are you aware of any problems your mother had during her pregnancy/delivery that produced you? ..... <input type="checkbox"/> Yes <input type="checkbox"/> No		

DO YOU:

	Yes	No	If Yes, Amount Per Day
Smoke			
Drink coffee/tea/colas			
Drink beer/wine			
Drink liquor			
Use illicit drugs			

Do you exercise on a REGULAR basis? \_\_\_\_\_ What type(s)? \_\_\_\_\_

Any family history (parents, grandparents, sitters, borthers) of:

Tyhroid disorders _____	Cancer _____	Allergies _____
Diabetes _____	Liver disease _____	Stroke _____
Migraines _____	Tuberculosis _____	Heart disease _____
High blood pressure _____	Rheumatoid arthritis _____	Kidney stones _____

For office use only:  
 Wt. \_\_\_\_\_ B/P \_\_\_\_\_  
 Ht. \_\_\_\_\_ H.R. \_\_\_\_\_  
 B.S. \_\_\_\_\_

PATIENT'S NAME \_\_\_\_\_