**Date:**_____ **Name**:_____ **DOB:**_____ **Age:**_____

**Weight:** _____ **Height:** _____ **Marital Status: M S W D** **Children #**_____ **Ages:** _____

**Occupation:** _____ **Reason for visit:** _____

_____

**A. General**

Do you feel depressed a lot of the time? yes no
Has there been any unusual weight gain or loss recently? yes no

**B. Skin**

*Have you noticed:*

Any skin rashes or itching? yes no
Any growth on your skin that bothers you? yes no
Any sores or wounds that do not heal? yes no
Any change in color or size of moles? yes no

**C. Eyes:**

Date of last eye exam:_____
Have you had:
Cataracts? yes no
Glaucoma? yes no

**D. ENT**

*Do you have:*

Any trouble hearing? yes no
Earaches or discharges from your ears? yes no
Drainage down the back of your throat? yes no
Frequent or severe nose bleeds? yes no
Persistent hoarseness? yes no

**E. Respiratory:**

*Do you have:*

A constant or bothersome cough? yes no
Coughing up blood? yes no
Sputum or phlegm between colds? yes no
Difficulty breathing? yes no
Have you noticed any wheezing or whistling? yes no

**F.Cardiovascular:**

Do you have pain or pressure over the front or back of your chest? yes no
If yes is it when walking fast, working hard, or when excited? yes no
Have you had an abnormal EEG? yes no
Do you have swelling of your feet or ankles? yes no
Does your heart ever beat fast or irregularly when you walk? yes no
Do you ever awaken at night with severe severe difficulty breathing? yes no

**G. Gastrointestinal:**

Have you recently had any change in your eating habits? yes no
Have you recently had any trouble swallowing? yes no
Do you have indigestion/heartburn? yes no
Have you ever vomited blood? yes no
Are you bothered with constipation? yes no
Do you have frequent loose stools? yes no
Do you ever awaken at night with a feeling of fullness underneath your breast? yes no
Have you ever passed blood? yes no
Have you ever had black or tarry stools? yes no
Have you noticed any recent changes in your bowel movements? yes no
Do you take laxatives? yes no
Do you have frequent nausea and/or vomiting? yes no

**H. Genitourinary**

*Do you have:*

Burning or pain when you urinate? yes no
Pass urine frequently? yes no
Trouble urinating? yes no
To get up at night to urinate? yes no
Trouble losing urine when you cough/sneeze? yes no
A problem with dribbling urine? yes no

**I. Musculoskeletal**

Do you have a problem with back pain? yes no
Do you have joint pain or stiffness? yes no
Which Joints?_____

**J. Central nervous system**

Do you have frequent or severe headaches? yes no
Do you often have spells of dizziness or faintness or light headedness? yes no
Have you recently fainted, blacked out, or lost consciousness? yes no
Have you ever had a seizure? yes no
Do you have numbness or tingling in your head arms or legs? yes no
Do you consider yourself a nervous person? yes no
Do you cry a lot for no reason? yes no
Have you ever had an urge to commit suicide? yes no

**K. *Women only***

When did you first start your periods?_____
Are your menstrual cycles irregular? yes no
Are your periods heavy? yes no
Frequency of periods_____
Have you passed the menopause or change? yes no
Have you had any lumps in your breast? yes no
Have you had any discharge from your nipples? yes no
Are you using any birth control measures? yes no

**PERSONAL**

| | | | |
|---|---|---|---|
| **Diabetes** | ☐ | **Cancer** | ☐ |
| **Heart attack** | ☐ | **Freq. kidney infectio** | ☐ |
| **Other heart disease** | ☐ | **Bladder infections** | ☐ |
| **Angina** | ☐ | **Nervous breakdown** | ☐ |
| **High blood pressure** | ☐ | **Thyroid disease** | ☐ |
| **Kidney disease** | ☐ | **Stomach disease** | ☐ |
| **Gout** | ☐ | **Gallbladder disease** | ☐ |
| **Asthma** | ☐ | **Jaundice** | ☐ |
| **Freq. lung infections** | ☐ | **Hepatitis** | ☐ |
| **Emphysema** | ☐ | **Colitis** | ☐ |
| **Rheumatic fever** | ☐ | **Arthritis** | ☐ |
| **Vertigo/tinnitus** | ☐ | **Migraine** | ☐ |
| **Cholesterol/lipids** | ☐ | **Other headaches** | ☐ |
| **Depression/anxiety** | ☐ | **Visual problems** | ☐ |
| **Other mental health issues** | ☐ | **Hearing problems** | ☐ |

Allergies to medications:_____ yes no

_____

***Do you regularly:***

Smoke: Cigarettes #_____ yes no

Pipe/cigars #_____ yes no

Smokeless tobacco _____ yes no

Other drug use? _____ yes no

Drink Alcohol: type/oz a day _____ yes no

Caffeinated beverages: type/oz_____yes no

Work more than 60 hrs/week _____yes no

## Hospitalizations: (other than surgeries)

_____ _____

_____ _____

_____ _____

## Surgeries: *(list and indicate approximate year)*

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

## Special Diagnostic Studies: (MRI CT US X-RAY'S)

_____

_____

_____

_____

***Name:***

## Family History

| | | (if living) List any health issues | (if deceased) Age of death & cause |
|---|---|---|---|
| **Father/Mother** | **Age:** | | |
| _____ | _____ **M F** | _____ | |
| _____ | _____ **M F** | _____ | |
| **Brothers/Sisters** | **Age:** | | |
| _____ | _____ **M F** | _____ | |
| _____ | _____ **M F** | _____ | |
| _____ | _____ **M F** | _____ | |
| _____ | _____ **M F** | _____ | |
| _____ | _____ **M F** | _____ | |
| _____ | _____ **M F** | _____ | |
| **Husband/Wife** | | | |
| _____ | _____ **M F** | _____ | |
| **Children** | **Age:** | | |
| _____ | _____ **M F** | _____ | |
| _____ | _____ **M F** | _____ | |
| _____ | _____ **M F** | _____ | |
| _____ | _____ **M F** | _____ | |
| _____ | _____ **M F** | _____ | |
| _____ | _____ **M F** | _____ | |
| _____ | _____ **M F** | _____ | |

***Have any of your relatives had any of the following: (circle)***

**Cancer**
**Hypertension**
**Diabetes**
**Heart Disease**
**High cholesterol**
**Arthritis or other rheumatological conditions**
**Alzheimer's disease/dementia**
**Stroke**
**Migraine**
**Epilepsy**
**Parkinson's disease**
**Brain aneurysms**
**High cholesterol**
**Multiple sclerosis**
**Any other family medical history _____**