

PATIENT INFORMATION:

FULL NAME:	SEX:	AGE:	DOB:
------------	------	------	------

Height: _____ Weight: _____

Reason for Visit (chief complaint including date of onset): _____

DO YOU OR HAVE YOU EVER HAD:

Yes	No		Yes	No		Yes	No	
<input type="checkbox"/>	<input type="checkbox"/>	HIGH BLOOD PRESSURE	<input type="checkbox"/>	<input type="checkbox"/>	BLEEDING TENDENCIES	<input type="checkbox"/>	<input type="checkbox"/>	SYNCOPE/FAINTING
<input type="checkbox"/>	<input type="checkbox"/>	STROKE	<input type="checkbox"/>	<input type="checkbox"/>	ANEMIA	<input type="checkbox"/>	<input type="checkbox"/>	CHRONIC SWOLLEN GLANDS
<input type="checkbox"/>	<input type="checkbox"/>	HEART ATTACK	<input type="checkbox"/>	<input type="checkbox"/>	AIDS/HIV	<input type="checkbox"/>	<input type="checkbox"/>	VISUAL IMPAIRMENT/ DRY EYE
<input type="checkbox"/>	<input type="checkbox"/>	IRREGULAR HEART BEATS	<input type="checkbox"/>	<input type="checkbox"/>	TRANSFUSIONS	<input type="checkbox"/>	<input type="checkbox"/>	CATARACTS
<input type="checkbox"/>	<input type="checkbox"/>	THROMBOPHLEBITIS /BLOOD CLOTS	<input type="checkbox"/>	<input type="checkbox"/>	DIABETES	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT EAR PROBLEMS
<input type="checkbox"/>	<input type="checkbox"/>	RHEUMATIC FEVER/ HEART MURMUR	<input type="checkbox"/>	<input type="checkbox"/>	THYROID PROBLEMS	<input type="checkbox"/>	<input type="checkbox"/>	FREQUENT NASAL BLEEDING
<input type="checkbox"/>	<input type="checkbox"/>	CHEST PAIN	<input type="checkbox"/>	<input type="checkbox"/>	HEPATITIS/ JAUNDICE	<input type="checkbox"/>	<input type="checkbox"/>	SKIN PROBLEMS REQUIRING MEDS
<input type="checkbox"/>	<input type="checkbox"/>	SHORTNESS OF BREATH	<input type="checkbox"/>	<input type="checkbox"/>	KIDNEY DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	MENTAL ILLNESS
<input type="checkbox"/>	<input type="checkbox"/>	ASTHMA/ EMPHYSEMA/ WHEEZING	<input type="checkbox"/>	<input type="checkbox"/>	BLOODY STOOL	<input type="checkbox"/>	<input type="checkbox"/>	BREAST LUMPS OR DISCHARGE
<input type="checkbox"/>	<input type="checkbox"/>	COLLAGEN VASCULAR DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	BOWEL OBSTRUCTIONS	<input type="checkbox"/>	<input type="checkbox"/>	BREAST IMPLANTS
<input type="checkbox"/>	<input type="checkbox"/>	PNEUMONIA	<input type="checkbox"/>	<input type="checkbox"/>	STOMACH ULCERS	<input type="checkbox"/>	<input type="checkbox"/>	HERNIA OF: _____
<input type="checkbox"/>	<input type="checkbox"/>	BACK OR NECK INJURIES	<input type="checkbox"/>	<input type="checkbox"/>	BLADDER INFECTION	<input type="checkbox"/>	<input type="checkbox"/>	CANCER OF / DATE: _____
<input type="checkbox"/>	<input type="checkbox"/>	COLD SORES/HERPES/SHINGLES	<input type="checkbox"/>	<input type="checkbox"/>	ABNORMAL X-RAY/MAMMOGRAM	<input type="checkbox"/>	<input type="checkbox"/>	RECENT WEIGHT LOSS OR GAIN AMOUNT: _____
<input type="checkbox"/>	<input type="checkbox"/>	SEXUALLY TRANSMITTED DISEASE	<input type="checkbox"/>	<input type="checkbox"/>	SEIZURES			
<input type="checkbox"/>	<input type="checkbox"/>	INJURIES OR FRACTURES: WHERE/ WHEN: _____						
<input type="checkbox"/>	<input type="checkbox"/>	OTHER: _____						
<input type="checkbox"/>	<input type="checkbox"/>	MEDICATIONS (include vitamins/herbs/over-the-counter): _____						

ALLERGIES & SIDE EFFECTS: _____

OPERATIONS/ HOPSITALIZATIONS/ ER VISITS/ COSMETIC PROCEDURES (LIST AND DATE): _____

PRIMARY CARE DOCTOR: _____ PHONE: _____ LAST EXAM : _____

GYNCOLOGIST: _____ PHONE: _____ LAST EXAM: _____

ONSET OF LAST MENSTRUAL CYCLE : (DATE) _____ Regular Irregular

NUMBER OF PREGNANCIES: _____ NUMBER OF BIRTHS: _____ METHOD OF BIRTH CONTROL: _____

COULD YOU BE PREGNANT NOW? YES NO

FAMILY HISTORY

FAMILY HISTORY OF DISEASE: LIST FAMILY MEMBER AND DATE

<input type="checkbox"/> DIABETES _____	<input type="checkbox"/> CANCER _____
<input type="checkbox"/> STROKE _____	<input type="checkbox"/> HYPERTENSION _____
<input type="checkbox"/> HEART DISEASE _____	<input type="checkbox"/> OTHER _____

SOCIAL HISTORY

DO YOU SMOKE? YES / HOW MUCH? _____ NO/ DATE QUIT: _____ NEVER

DO YOU DRINK ALCOHOL? YES / HOW MUCH? _____ NO: _____

LABORATORY STUDIES (DATE AND LOCATION)

YES	NO		YES	NO	
<input type="checkbox"/>	<input type="checkbox"/>	BLOOD TESTS (CBC)	<input type="checkbox"/>	<input type="checkbox"/>	CHEST X-RAY/MRI/CT
<input type="checkbox"/>	<input type="checkbox"/>	EKG (CARDIOGRAM)	<input type="checkbox"/>	<input type="checkbox"/>	OTHER LAB _____
<input type="checkbox"/>	<input type="checkbox"/>	MAMMOGRAM DATE: _____			LOCATION: _____

I CERTIFY THAT I HAVE DISCLOSED MY MEDICAL HISTORY TO THE BEST OF MY KNOWLEDGE.

PATIENT SIGNATURE: _____ DATE: _____