

NAME _____ TODAY'S DATE _____

STREET _____ CITY _____ STATE _____ ZIP _____

HOME # _____ CELL # _____ WORK # _____

OCCUPATION _____ AGE: _____ DATE OF BIRTH _____

REFERRED BY _____ SS# _____

MARITAL STATUS _____ Single Married Widowed Divorced

Caucasian Black Hispanic Other

EMAIL ADDRESS _____

BRIEFLY, WHAT IS THE PURPOSE OF THIS VISIT?

HISTORY OF PRESENT ILLNESS: (Leave this blank, the Dr. will discuss with you.)

Location
Quality
Severity
Duration
Timing
Context
Modifying
Factors
Assoc. S/Sxs

Family History:

Have you or any member of your family had any of the following:

			What Relative / Yourself	Age	Age at Death
Cancer/Leukemia	N	Y	_____ / _____		
Tuberculosis	N	Y	_____ / _____	Father	_____
Diabetes	N	Y	_____ / _____	Mother	_____
Heart Trouble	N	Y	_____ / _____	Brothers	_____
Heart Attack	N	Y	_____ / _____		_____
High Blood Pressure	N	Y	_____ / _____		_____
Stroke	N	Y	_____ / _____		_____
Epilepsy	N	Y	_____ / _____	Sisters	_____
Bleeding Disorder	N	Y	_____ / _____		_____
Asthma	N	Y	_____ / _____		_____
Migraine Headaches	N	Y	_____ / _____		_____
Alcoholism	N	Y	_____ / _____	Children	_____
Emphysema	N	Y	_____ / _____		_____
Stomach or Duodenal Ulcer	N	Y	_____ / _____		_____
Kidney Disease	N	Y	_____ / _____		_____
Sickle Cell Anemia	N	Y	_____ / _____		_____
Anemia	N	Y	_____ / _____		_____
Mental Illness	N	Y	_____ / _____		_____
Suicide	N	Y	_____ / _____		_____
Other Serious Disease	N	Y	_____ / _____		_____

Reviewed by: Dr. _____ Date _____

How much do you smoke? _____ How long have you smoked? _____

If you smoked in the past, when did you stop? _____

How much alcohol do you drink on the average per day or week? _____

Do you use recreational drugs? _____ How much caffeine do you consume in a day? _____

Are you on a special diet? _____ What diet? _____

Have you recently gained or lost weight? Gained? _____ Lost _____ N/A _____

Have you ever had a blood transfusion? _____ If yes, give approximate dates _____

Does your work expose you to: Stress _____ Heavy Lifting _____ Hazardous Substances _____?

OPERATIONS:

ALLERGIES:

Have you had any of the following?

Are you allergic to any of the following?

	NO	YES	DATE
Hemorrhoids	_____	_____	_____
Tonsils	_____	_____	_____
Appendix	_____	_____	_____
Gallbladder	_____	_____	_____
Small Intestine	_____	_____	_____
Kidney	_____	_____	_____
Colon	_____	_____	_____
Thyroid	_____	_____	_____
Hernia (rupture)	_____	_____	_____
Stomach	_____	_____	_____
Breast	_____	_____	_____
Uterus	_____	_____	_____
Ovaries	_____	_____	_____
Prostate	_____	_____	_____
Other Surgery	_____	_____	_____
If yes, please name _____			

Other Hospitalizations	_____	_____	_____
If yes, please name _____			

	NO	YES
Penicillin	_____	_____
Sulfa	_____	_____
Other Antibiotics	_____	_____
If so, please name _____		

Any other drug or medicine	_____	_____
If so, please name _____		

MEDICATIONS:

Please list all medications.

NAME	/STRENGTH	/HOW OFTEN?
_____	/	/
_____	/	/
_____	/	/
_____	/	/
_____	/	/
_____	/	/
_____	/	/
_____	/	/
_____	/	/
_____	/	/

Specifically, do you take any of the following over-the-counter supplements?

- METABOLIFE (or equivalent)
- GINKOBA BILOBA
- GINGER
- ST JOHN'S WORT
- GINSENG
- OTHERS

Dr. INITIAL _____ Date _____

SYSTEM REVIEW: Do you have any of the following complaints?

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GENERAL	NO	YES	KIDNEY	NO	YES
Fever	_____	_____	Kidney Stones	_____	_____
General Weakness	_____	_____	Blood in Urine	_____	_____
Memory Loss	_____	_____	Pain/Burning while Urinating	_____	_____
Easy Bruising	_____	_____	Difficulty Passing Urine	_____	_____
Diabetes	_____	_____	Difficulty Controlling Urine	_____	_____
			Getting Up at Night to Urinate	_____	_____
			Other _____	_____	_____
HEAD					
Trouble with Vision	_____	_____			
Trouble with Ears	_____	_____	WOMEN		
Sinus Trouble	_____	_____	Breast Lump	_____	_____
Persistent Hoarseness	_____	_____	Discharge from Nipple	_____	_____
Severe Headaches	_____	_____	Vaginal Discharge	_____	_____
Other _____	_____	_____	Vaginal Bleeding or Spotting (Not with Periods)	_____	_____
			Hot Flashes	_____	_____
SKIN			Possibly Pregnant	_____	_____
Changing Mole	_____	_____	Other _____	_____	_____
Rash	_____	_____			
Other Skin Problems	_____	_____	MEN		
			Prostate Trouble	_____	_____
NECK			Discharge from Penis	_____	_____
Swelling	_____	_____	Sore on Penis	_____	_____
Lumps	_____	_____	Lump in Testicles	_____	_____
Stiffness	_____	_____	Difficulty having erections	_____	_____
Other _____	_____	_____	Other _____	_____	_____
CHEST, HEART, LUNGS			NEUROMUSCULAR		
Shortness of Breath	_____	_____	Weakness in Arm or Leg	_____	_____
Poor Exercise Tolerance	_____	_____	Dizzy Spells	_____	_____
High Blood Pressure	_____	_____	Fainting Spells	_____	_____
Fluttering of Heart	_____	_____	Other _____	_____	_____
Chest Pain or Pressure Attacks	_____	_____			
Frequent Cough	_____	_____	BONES- JOINTS		
Coughing Up Blood	_____	_____	Painful Joints	_____	_____
Wheezing	_____	_____	Swollen Joints	_____	_____
Night Sweats	_____	_____	Loss of Muscle Strength	_____	_____
Swollen Ankles	_____	_____	Lump or Swelling in Muscle	_____	_____
Other _____	_____	_____	Back Pain	_____	_____
			Other _____	_____	_____
GASTROINTESTINAL			PSYCHOLOGICAL		
Poor Appetite	_____	_____	Do you find your life:		
Indigestion or Heartburn	_____	_____	Generally Unsatisfactory	_____	_____
Difficulty Swallowing	_____	_____	Boring	_____	_____
Nausea or Vomiting	_____	_____	Satisfactory	_____	_____
Vomiting Blood	_____	_____			
Abdominal Pain or Cramps	_____	_____	Do you:		
Abdominal Swelling	_____	_____	Cry Easily	_____	_____
Diarrhea	_____	_____	Feel Anxious or Upset	_____	_____
Constipation	_____	_____	Have Difficulty with Sleep	_____	_____
Change in Bowel Habits	_____	_____			
Pass Blood from Rectum	_____	_____			
Black, Tar-Like Bowel Movements	_____	_____			
Other _____	_____	_____			

Dr. INITIAL _____ Date _____