

Name \_\_\_\_\_ Age \_\_\_\_\_ Chart# \_\_\_\_\_  
 Social Security # \_\_\_\_\_ Referred by \_\_\_\_\_  
 New  Updated Data \_\_\_\_\_ Date \_\_\_\_\_  
 Reason For Today's Visit \_\_\_\_\_ Family Physician \_\_\_\_\_

**PREVIOUS SURGERY -**

Have you ever been operated on for any of the following:

	Date		Date
<input type="checkbox"/> Colonoscopy/BE	_____	<input type="checkbox"/> Heart Surgery	_____
<input type="checkbox"/> Appendectomy	_____	<input type="checkbox"/> Breast Surgery	_____
<input type="checkbox"/> Hysterectomy	_____	<input type="checkbox"/> Hernias	_____
<input type="checkbox"/> Gallbladder	_____	<input type="checkbox"/> Hemorrhoidectomy	_____
<input type="checkbox"/> Colon	_____	<input type="checkbox"/> Tonsils	_____
<input type="checkbox"/> Vascular Surgery	_____	<input type="checkbox"/> Laparoscopy	_____
Others: _____			

Remarks: \_\_\_\_\_

If necessary, would you agree to blood or blood products? Yes No (Circle One)

**MEDICAL HISTORY -**

Do you or any family members have a history of any of the following:

	Yourself	Family		Yourself	Family
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>
Cancer - Other Type _____	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	Lung Disease	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
HIV	<input type="checkbox"/>	<input type="checkbox"/>	Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Colon Disease	<input type="checkbox"/>	<input type="checkbox"/>	Others _____	<input type="checkbox"/>	<input type="checkbox"/>

**ALLERGIES TO MEDICATIONS** (Please List medicine with symptoms) Allergy to Latex  Yes  No

**MEDICATIONS -** (Please check)  Aspirin  Steroids  Coumadin

 Are you taking any other medications?  Yes  No

Medicine Name	Dosage	How many times a day?
_____	_____	_____
_____	_____	_____

Do you smoke?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much? _____	How long? _____
If No, did you previously?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much? _____	How long? _____
Do you drink alcohol?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much? _____	How long? _____
Do you use caffeine?	<input type="checkbox"/> Yes <input type="checkbox"/> No	How much? _____	
Do you wear glasses?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Contacts? <input type="checkbox"/> Yes <input type="checkbox"/> No	Hearing Aid? <input type="checkbox"/> Yes <input type="checkbox"/> No Dentures? <input type="checkbox"/> Yes <input type="checkbox"/> No

**FOR FEMALES -**

Date of last period _____	Last Mammogram? _____	<input type="checkbox"/> Menopause
How many pregnancies? _____	How many children? _____	Breastfeed <input type="checkbox"/> Yes <input type="checkbox"/> No
Last pap smear _____	Type of Birth Control _____	

NAME: \_\_\_\_\_ SSN: \_\_\_\_\_ DATE: \_\_\_\_\_

## REVIEW OF SYSTEMS

*Check symptoms you currently have or have had in the past year:*

### GENERAL

- weight loss
- fevers
- night sweats
- fatigue

### SKIN

- rashes
- color change
- sores

### NECK

- swollen glands
- pain
- stiffness

### LUNGS

- chronic cough
- coughed-up blood
- asthma or bronchitis
- pneumonia or tuberculosis
- emphysema

### HEART

- chest pain
- shortness of breath
- leg swelling
- irregular heart beat
- rapid heart beat

### GASTROINTESTINAL

- trouble swallowing
- heartburn
- nausea or vomiting
- change in your appetite
- vomiting blood
- blood in your bowel movements
- black bowel movements
- diarrhea
- constipation
- jaundice or liver trouble
- gallstones

### KIDNEY

- burning or pain when urinating
- kidney stones
- urinate frequently during the night
- urine infections
- blood in urine

### VASCULAR

- leg cramps
- varicose veins
- blood clots

### BLOOD

- low blood count or anemia
- easy bruising or bleeding
- ever had a blood transfusion

### ENDOCRINE

- heat or cold intolerance
- excessive sweating
- excessive thirst or hunger

### WOMEN only

- breast lump(s)
- breast pain
- nipple discharge
- breast skin dimpling
- perform breast self exams
- vaginal discharge
- abnormal vaginal bleeding

### MEN only

- breast lump
- lump in testicle
- discharge from penis
- sore on penis
- bulge in groin or hernia

### OTHER

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

Doctor's Initials: \_\_\_\_\_