

Please take time to update the following information for our files. This information is treated with strict confidentiality and will help us obtain a comprehensive assessment of your health care needs.

NAME	BIRTH DATE	DATE
CHIEF COMPLAINTS: <i>(Please list current symptoms)</i>		
1.	3.	
2.	4.	

PAST MEDICAL HISTORY: <i>Hospitalizations and Surgeries</i>			
Reason/Diagnosis/Procedure	Date	Reason/Diagnosis/Procedure	Date

MEDICAL ILLNESSES OR CONDITIONS: <i>(Conditions you now have or have had in the past.)</i>					
Condition	Onset Date	Condition	Onset Date	Condition	Onset Date
<input type="checkbox"/> Migraine headaches	_____	<input type="checkbox"/> Stomach or duodenal ulcer	_____	<input type="checkbox"/> Goiter	_____
<input type="checkbox"/> Seizures or convulsions	_____	<input type="checkbox"/> Hepatitis	_____	<input type="checkbox"/> Gonorrhea	_____
<input type="checkbox"/> Stroke	_____	<input type="checkbox"/> Cirrhosis	_____	<input type="checkbox"/> Syphilis or VD	_____
<input type="checkbox"/> Polio	_____	<input type="checkbox"/> Gall stones	_____	<input type="checkbox"/> HIV infection	_____
<input type="checkbox"/> Glaucoma	_____	<input type="checkbox"/> Colon or bowel trouble	_____	<input type="checkbox"/> Herpes infection	_____
<input type="checkbox"/> Cataracts	_____	<input type="checkbox"/> Dysentery or serious diarrhea	_____	<input type="checkbox"/> Chicken pox	_____
<input type="checkbox"/> Blindness	_____	<input type="checkbox"/> Rectal trouble	_____	<input type="checkbox"/> Mumps	_____
<input type="checkbox"/> Recurrent ear infections	_____	<input type="checkbox"/> Hemorrhoids	_____	<input type="checkbox"/> Measles	_____
<input type="checkbox"/> Deafness	_____	<input type="checkbox"/> Recurrent urinary infections	_____	<input type="checkbox"/> Recurrent boils	_____
<input type="checkbox"/> Hay fever, allergic nose	_____	<input type="checkbox"/> Kidney stones	_____	<input type="checkbox"/> Skin problems	_____
<input type="checkbox"/> Recurrent sinusitis	_____	<input type="checkbox"/> Other kidney disease	_____	<input type="checkbox"/> Serious depression	_____
<input type="checkbox"/> Asthma	_____	<input type="checkbox"/> Arthritis	_____	<input type="checkbox"/> Serious emotional problems	_____
<input type="checkbox"/> Chronic bronchitis	_____	<input type="checkbox"/> Gout	_____	<input type="checkbox"/> Nervous breakdown	_____
<input type="checkbox"/> Emphysema	_____	<input type="checkbox"/> Broken bones	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Tuberculosis	_____	<input type="checkbox"/> Varicose veins	_____	<input type="checkbox"/> Other _____	_____
<input type="checkbox"/> Heart murmur	_____	<input type="checkbox"/> Phlebitis or blood clots	_____	Women	
<input type="checkbox"/> Heart attack	_____	<input type="checkbox"/> Bleeding problems	_____	<input type="checkbox"/> Menstrual difficulties	_____
<input type="checkbox"/> Angina	_____	<input type="checkbox"/> Anemia	_____	<input type="checkbox"/> Abnormal PAP	_____
<input type="checkbox"/> Enlarged heart	_____	<input type="checkbox"/> Cancer (Type: _____)	_____	<input type="checkbox"/> Ovarian cyst(s)	_____
<input type="checkbox"/> Rheumatic fever	_____	<input type="checkbox"/> Diabetes	_____	<input type="checkbox"/> Breast lump(s)	_____
<input type="checkbox"/> High blood pressure	_____	<input type="checkbox"/> Overactive thyroid	_____	Men	
<input type="checkbox"/> Hiatal hernia / chronic heartburn	_____	<input type="checkbox"/> Underactive thyroid	_____	<input type="checkbox"/> Prostate trouble	_____

CURRENT MEDICATIONS: <i>(Include non-prescription products)</i>		ALLERGIES: <i>(Include drugs, foods, chemicals, insects, etc.)</i>	
Drug Name	Dose	Item	Type of Reaction

FAMILY HISTORY: *Please complete the following information on your relatives.*

	Living	Dead	Age	Chronic Condition(s)/Cause of Death
Father				
Mother				
Brothers (No._____) & Sisters (No._____) _____				

Spouse				
Children (No._____) _____				

SOCIAL/PERSONAL HISTORY: *Please complete the following information about yourself.*

Current occupation: _____

Education completed:

 Grade: _____ High School College: _____ years, degree/major _____ Post-graduate: _____Marital status: Single Married (Date: _____) Separated (Date: _____) Divorce (Date: _____)
 Widowed (Date: _____)

Married _____ time(s): #1: _____ yrs, _____ children #2: _____ yrs, _____ children #3: _____ yrs, _____ children

Personal habits: *(check all that apply)* Currently use tobacco: Type: Cigarettes Cigars Pipe Smokeless tobacco Amount /day: _____ Years: _____ Former smoker: Amount /day: _____ Years: _____ Quit Date: _____ Exposed to second-hand smoke Consume alcohol: Type: _____ Amount/day: _____ Use recreational drugs: Type: _____ Frequency: _____ Consume caffeine: Beverage: _____ Amount/day: _____ Exercise regularly: Type: _____ Frequency/week: _____ Wear my seatbelt: Frequency (%): _____Sexual history: Multiple sex partners Prefer opposite sex Prefer same-sex relationships**REVIEW OF SYSTEMS:** *(Please check any item which describes recent or ongoing symptoms)***General:** None apply Significant weight loss Loss of feeling of well-being Fatigue or loss of energy Difficulty sleeping

Comment: _____

Ear-Nose-Throat: None apply Chronic headaches Hearing loss Ringing in ears Dizziness Chronic nasal congestion Recurring sinus infections Nose bleeds Nasal obstruction Bleeding gums Sore throat Toothache Breath odor Hoarseness

Comment: _____

Name: _____ Birthdate: _____ Date: _____

Respiratory:

None apply

- Shortness of breath Cough Chest congestion Wheezing
 Coughing up blood Choking Noisy breathing
 History of pneumonia History of Tuberculosis (TB)

Comment: _____

Cardiovascular:

None apply

- Chest pain Heart fluttering/racing Heart murmur Decreased exercise tolerance
 Awakening due to shortness of breath Difficulty breathing when lying down Leg swelling
 Pain in buttocks or legs with exercise Sensitivity of hands/feet to temperature changes

Comment: _____

Gastrointestinal:

None apply

- Stomach pains Nausea Vomiting Diarrhea Constipation
 Frequent heartburn Indigestion Belching/sour taste Difficulty swallowing Bloating
 History of hepatitis History of yellow jaundice

Rectal:

- Rectal bleeding Rectal pain or irritation Swelling or hemorrhoids

Comment: _____

Lymphatic/Hematologic:

None apply

- Unusual lymph node swelling (in neck, arm pit, or groin) Painful lymph nodes
 History of anemia Blood clots Bruise easily Unusual bleeding

Comment: _____

Musculoskeletal:

None apply

- Limb or joint pains Limb or joint deformity Limb or joint swelling/stiffness/redness
 Muscle weakness Loss of muscle bulk Muscle spasms or twitching
 Recurring back/neck pain Back/neck injury

Comment: _____

Neurologic:

None apply

- Seizures Tremors/shakiness Unusual clumsiness Limb weakness Numbness/tingling Stroke
 History of significant head injury Altered consciousness or black-outs

Comment: _____

Psychologic:

None apply

- Lapses in memory Periods of confusion/disorientation Difficulty concentrating
 Troublesome depression Worry about things Mood swings History of mental illness
 Unusual stress History of physical or mental abuse

Comment: _____

Skin:

None apply

- Itching Rash Unusual dryness Changes in hair Changes in pigmentation

Comment: _____

Endocrine:

None apply

Unexpected changes in : Tolerance to heat Tolerance to cold Unusual thirst

Comment: _____

Allergy/Immunologic:

None apply

Seasonal allergies Sensitivity to specific items: _____

Frequent or unusual infections

Comment: _____