Instructions:

Place an "X" in boxes that apply to you.
Make no marks in boxes that do not apply to you.
Complete all sections

Past Medical History: Medical problems pertaining only to you:

Cardiac / Heart			
☐	**I have no history of heart or blood pressure problems.**		
☐	High Blood Pressure	☐	Mitral Valve Prolapse
☐	Heart Attack	☐	Elevated Cholesterol
☐	Angina	☐	Elevated /abnormal Lipids
☐	Atrial Fibrillation	☐	Heart murmur
☐	Irregular heart beat	☐	Congestive heart failure
☐	Other		

Respiratory / Lungs / Breathing			
☐	**I have no history of breathing or respiratory problems.**		
☐	Black Lung	☐	Pulmonary Embolism
☐	Obstructive disease COPD	☐	Sleep Apnea
☐	Asthma	☐	Lung Cancer
☐	Pneumonia	☐	Emphysema
☐	Bronchitis	☐	Other

Endocrine / Glands			
☐	**I have no history of endocrine / glandular problems**		
☐	Diabetes / Borderline or diet	☐	Thyroid:
☐	Diabetes / Pills	☐	Thyroid Cancer
☐	Diabetes requiring insulin	☐	Thyroid surgery
☐	Diabetes, Juvenile	☐	Other

Circulation / Vascular			
☐	**I have no history of vascular / circulation problems**		
☐	Bad Circulation	☐	Aneurysm
☐	Carotid artery blockage	☐	Aneurysm surgery
☐	Stroke / Mini stroke	☐	Arterial bypass (legs) surgery
☐	Blood clots	☐	Carotid surgery
☐	Varicose Veins	☐	Vena Cava filter
		☐	Other

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Arthritis / Musculoskeletal

- ☐ **I have no history of arthritis or musculoskeletal problems**

☐ Rheumatoid arthritis	☐ Scoliosis
☐ Osteoarthritis	☐ Neck surgery
☐ Fibromyalgia	☐ Back surgery
☐ Lupus	☐ Osteoporosis
☐ Osteoporosis	☐ Shoulder tendonitis
☐ Gout	☐ Hip bursitis
☐ Psuedogout	☐ Fractures (please list)
☐ Back pain	☐ Walk with cane / crutch / walker
☐ Neck pain	☐ Shoulder pain, tendonitis

Neurological

- ☐ **I have no history of neurological problems**

☐ Dementia / Alzheimers	☐ Migraines
☐ Tremor	☐ Headache (not migraine)
☐ Neuropathy	☐ Parkinson's disease
☐ Multiple Sclerosis	☐ Carpal tunnel
☐ Inherited neurological problems	☐ Stroke / Mini Strokes
☐ Polio	☐ Seizures / Epilepsy
☐ Problems with balance	☐ Other

Gastrointestinal / digestive

- ☐ **I have no history of gastrointestinal / digestive problems**

☐ Reflux / GERD	☐ Rectal or GI Bleeding
☐ Colitis	☐ Cirrhosis
☐ Ulcers	☐ Colon Cancer
☐ Hemorrhoids	☐ Pancreatitis
☐ Hepatitis	☐ Other

Genitourinary, Male (Men Only)

- ☐ **I have no history of genitourinary problems.**

☐ Prostate enlargement	☐ Prostate Cancer
☐ Testicle swelling	☐ Erectile dysfunction
☐ Prostatitis	☐ Incontinence
☐ Testicular cancer	☐ Bladder tumor
☐ Abnormal PSA	☐ Genital infections / lesions
☐ Other	

Genitourinary, Female (Women Only)

- ☐ **I have no history of genitourinary problems.**

☐ Urinary incontinence	☐ Breast cancer
☐ Frequent urinary infections	☐ Abnormal pap smear
☐ Ovarian cysts	☐ Cervical dysplasia
☐ Ovarian cancer	☐ Cervical cancer
☐ Endometriosis	☐ Other

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Female Menstrual / Birth History

- ☐ Age at start of menses ________
- ☐ Age at menopause ________
- ☐ Number of pregnancies ________
- ☐ Number of Births ________
- ☐ Number of C-sections ________

Renal / Kidneys

- ☐ **Il have no history of problems with my kidneys**

☐ Kidney Stones	☐ Renal Cancer
☐ Kidney failure	☐ Dialysis
☐ Other	☐

Blood

- ☐ **I have no problems with blood or blood disorders and have not received a transfusion.**

☐ Anemia	☐ Bleeding disorder
☐ Lymphoma	☐ B12 deficiency
☐ Multiple Myeloma	☐ Iron deficiency
☐ Other blood cancer	☐ Transfusion
☐ Blood clots (DVT)	☐ HIV, AIDS
☐ Immunosuppression	☐ Hepatitis C
☐ Lymph node enlargement	☐ Other

Hearing, Vision, Taste, Smell:

- ☐ **I have no problems, with vision, taste, smell and do not wear glasses**

☐ Hard of hearing	☐ Glasses / contacts
☐ Hearing aid	☐ Cataracts
☐ Ear surgery	☐ Glaucoma
☐ Neck surgery	☐ Macular degeneration
☐ Nosebleeds	☐ Retinal hemorrhages
☐ Loss of vision / blindness	☐ Other

Skin / Integument:

- ☐ **I have no history of skin problems / disorders**

☐ Skin cancer	☐ Rosacea
☐ Melanoma	☐ Skin breakdown / ulcers
☐ Skin cancer surgery	☐ Varicose veins
☐ Rashes	☐ Veinous isufficiency
☐ Excema	☐ Lymphedema, chronic swelling
☐ Psoriasis	☐ Acne

Behavior / Mood / Psychological

- ☐ **I have no history mood problems / disorders**

☐ Depression	☐ Alcoholism
☐ Bipolar	☐ Drug use / addiction
☐ Manic	☐ Other

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Past Surgeries / Invasive Procedures						
☐	**I have had no surgeries or invasive procedures**					
	Surgery	**Date**			**Surgery**	**Date**
☐	Gallbladder			☐	Tonsils	
☐	Appendix			☐	Hernia	
☐	Thyroid			☐	Hemorrhoids	
☐	Cardiac catheterization			☐	Splenectomy	
☐	Cardiac Stents			☐	Colonoscopy	
☐	Cardiac Bypass			☐	EGD endoscopy, upper	
☐	Other cardiac surgery			☐	Colon surgery	
☐	Breast / Right			☐	Colostomy	
☐	Breast / Left			☐	Colonoscopy	
☐	Hysterectomy/ total			☐	Other abdominal surgery	
☐	Hysterectomy / partial			☐	Lung Surgery	
☐	Tubal ligation			☐	Lithotripsy	
☐	Laparoscopy			☐	Open kidney stones	
☐	Other female surgery			☐	Vasectomy	
☐	Bladder repair			☐	Prostate biopsy	
☐	Vascular bypass			☐	Prostate resection	
☐	Carotid			☐	Prostate shrink	
☐	Cystoscopy			☐	Prostate seed	
☐	Nose surgery			☐	Kidney surgery	
☐	Ear Surgery			☐	Cataract ☐R☐L	
☐	Carpal tunnel Right			☐	Corneal surgery	
☐	Carpal Tunnel Left			☐	Other Right Hand	
☐	Shoulder, Right			☐	Other Left Hand	
☐	Elbow, Right			☐	Shoulder Left	
☐	Wrist, Right			☐	Elbow Left	
☐	Fingers Right			☐	Wrist, Left	
☐	Hip, Right			☐	Fingers Left	
☐	Knee Right			☐	Hip, Left	
☐	Ankle Right			☐	Knee, Left	
☐	Foot / Toes Right			☐	Ankle, Left	
☐	Radiation treatments			☐	Foot / Toes Left	
☐	Other surgery				Chemotherapy	

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Social History

Marital Status	Use of Alcohol	Use of Tobacco	Living Situation
☐ Single	☐ Never	☐ Never	☐ Alone
☐ Married	☐ Rarely	☐ Quit	☐ With family
☐ Divorced	☐ Moderate	☐ Currently	☐ Home Help
☐ Widowed	☐ Daily	____ packs/ day	☐ Facility
☐ Separated			

Family History: Medical information pertaining to blood relatives:

Mother ☐ Alive ☐ Unknown
☐ Deceased Age at death: _____
Cause of death ____

Father ☐ Alive ☐ Unknown
☐ Deceased Age at death: _____
Cause of death ____

Medical conditions in blood relatives:
Mark an "X" only in boxes that apply. Leave all other boxes blank.

Condition	Mother	Father	Brother / Sister	Other blood relative
Death before age 50	☐	☐	☐	☐
Heart attack	☐	☐	☐	☐
High blood pressure	☐	☐	☐	☐
Stroke	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐
Breast cancer	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐
Bleeding disorders	☐	☐	☐	☐
Neurologic disorder	☐	☐	☐	☐
Sickle cell anemia	☐	☐	☐	☐
Uterine cancer	☐	☐	☐	☐
Ovarian cancer	☐	☐	☐	☐
Serious reaction to anesthesia other than nausea	☐	☐	☐	☐

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Medications:

- **Copy each medication name, strength and how taken for each medication. Write them exactly as written on the bottle.**
- **Please include over the counter medications and supplements.**
- **Bring medication bottles with you to your appointment.**

☐ **No medications**

Medication name	Strength	Dose / how taken	Last taken	D/C
Medication name	*10mg*	*Twice daily by mouth*	*today*	

Allergies / Drug sensitivities: Enter drug name and reaction

☐ **No Allergies**

Drug Name	Rash	Nausea	Swelling/ Short of breath	Other reaction (describe reaction)
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
	☐	☐	☐	☐
Latex:	☐	☐	☐	☐
NSAID / arthritis	☐	☐	☐	☐

Staff review:												
INI	Date											

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General System review:

General health
- ☐ Bad general health
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Fever
- ☐ Fatigue
- Headaches

Cardiovascular
- ☐ Heart trouble
- ☐ Chest pain. Angina
- ☐ Irregular heart beat
- ☐ Short of breath
- ☐ Swelling of feet
- ☐ Unable to climb 4 stairs

Respiratory
- ☐ Chronic cough
- ☐ Blood in sputum
- ☐ Shortness of breath
- ☐ Wheezing

Gastrointestinal
- ☐ Loss of appetite
- ☐ Nausea / vomiting
- ☐ Frequent diarrhea
- ☐ Constipation
- ☐ Rectal bleeding
- ☐ Abdominal pain

Endocrine
- ☐ Excessive thirst, urination
- ☐ Heat, cold intolerance
- ☐ Skin becoming dry

Musculoskeletal
- ☐ Joint pain
- ☐ Joint stiffness, swelling
- ☐ Weak muscles. joints
- ☐ Muscle pain, cramps
- ☐ Back pain
- ☐ Cold extremities
- ☐ Difficulty walking

Genitourinary
- ☐ Frequent urination
- ☐ Burning urination
- ☐ Blood in urine
- ☐ Incontinence / dribbling
- ☐ Decrease force / stream
- ☐ Male: discharge
- ☐ Male: testicle pain
- ☐ Female: painful periods
- ☐ Female vaginal discharge

Eyes
- ☐ Eye disease / injury
- ☐ Glasses / contact lens
- ☐ Blurred vision
- ☐ Double vision

Blood, Lymph
- ☐ Slow healing of cuts
- ☐ Bleeding tendency
- ☐ Bruise easily
- ☐ Anemia
- ☐ Enlarged glands
- ☐ Night Sweats

Psychiatric
- ☐ Memory loss / confusion
- ☐ Nervousness
- ☐ Depression
- ☐ Insomnia

Neurological
- ☐ Dizzy, lightheaded
- ☐ Numbness / tingling
- ☐ Tremors
- ☐ Paralysis

Skin, Breast
- ☐ Rash / itching
- ☐ Change in skin color
- ☐ Varicose veins
- ☐ Breast pain
- ☐ Breast lump

Ear, Nose, Throat
- ☐ Hearing loss, ringing
- ☐ Earaches, drainage
- ☐ Chronic sinus problem
- ☐ Nosebleeds
- ☐ Bleeding gums
- ☐ Sore throat
- ☐ Swollen neck glands

Dental
- ☐ Appliances
- ☐ Caries
- ☐ Dentures

☐ **Other: Any other condition you are concerned about:**

____

____

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Preventive Health:

Enter year and result for tests that you have had. Make <u>no marks</u> for tests that do not apply to you.

Test	Year	Result
Bone density		
Cholesterol / Triglycerides		
Colonoscopy		
Stool blood screening		
Rectal exam		
Female		
Breast exam		
Mammogram		
Pap smear		
Pelvic exam		
Male		
PSA		
Immunizations (shots)		
Tetanus		
Influenza (flu)		
Pneumococcal (pneumonia)		

Doctors taking care of me:	
Specialty	Name of Doctor
Primary	

Done

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