

(PLEASE PRINT)

(For Office Use Only)	
Review Dates	

Name: _____
 Date of Birth: _____ Birth Place: _____
 Who referred you here? _____
 Marital Status: _____
 Who lives in your household? _____

Why did you come to the office? _____
 What is your Occupation: _____
 Who is your Employer: _____
 How far did you go in school? Can you read? Yes No
 What languages do you speak? _____
 Do you have any pets? No Yes, If Yes, what kind of pet? _____

Medical History
 Allergies to medicines and any type of reaction: _____

Other allergies?: _____
 List all medications you use (include over-the-counter, non-prescription drugs and birth control pills)

Pharmacy you usually use: _____ Phone #: _____

Hospitalizations/Surgeries (Do not include normal pregnancy/delivery)

Year	Operation or illness	Location
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Any other physicians you currently see? _____

Who was your previous primary care physician? _____

Other Illness (Please check the boxes of ALL you have ever had and include the approximate year)

- | | |
|---|---|
| <input type="radio"/> ----- Measles | <input type="radio"/> _____ Hepatitis |
| <input type="radio"/> _____ Mumps | <input type="radio"/> _____ Stroke |
| <input type="radio"/> ----- Rubella (German measles) | <input type="radio"/> _____ Seizures |
| <input type="radio"/> ----- Chicken Pox | <input type="radio"/> _____ Unconsciousness |
| <input type="radio"/> - Exposure to Tuberculosis (TB) | <input type="radio"/> _____ Depression |
| <input type="radio"/> ----- Sexually transmitted disease
(eg. Gonorrhea/Chlamydia) | <input type="radio"/> _____ Anxiety |

Other Illness (*continued*) (Please check the boxes of ALL you have ever had and include the approximate year)

D	Panic attacks	D	Hay fever
D	Cataracs	D	Asthma
D	Glaucoma	D	Pneumonia
D	Eye trouble	D	Bad sunburn
D	Hearing loss	D	Broken bone
D	Swelling problems		which one:
D	Anemia	D	Jaundice
D	Bleeding disorder	D	Gall bladder disease
D	Cancer/type:	D	Ulcer
D	Radiation treatment	D	Intestinal disorder
D	Rheumatic fever	D	Kidney stone
D	High blood pressure	D	Urine infection
D	Heart murmur	D	Problems with urination
D	Heart attack	D	Diabetes
D	High Cholesterol	D	Gout
D	Circulatory problem	D	Thyroid disease
D	Leg swelling	D	Other:

List the year you had a:

Tetanus shot	Tuberculosis test	Result:
Flu shot	Cholesterol test	Result:
Pneumonia shot	Pap smear	Result:
Chickenpox shot ...	Mammogram	Result:
Hepatitis B shot	HIV test	Result:
Rubella or MMR ...	Eye exam	Dental exam

FOR WOMEN ONLY:

1. Are you having menstrual periods? D Yes D No, If NO, when did they stop? _____ (Skip to # 6)
2. How often do your periods occur? _____ Are they regular? D Yes D No LMP? _____
3. How many days does your period last? Is flow: D light D medium D heavy
4. Do you usually pass blood clots? D Yes D No
5. Do you have pain or discomfort before or during your period? D Yes D No
6. Have you ever had bleeding or spotting other than during your period? D Yes D No
7. Are you sexually active? D No D Yes, If Yes, What, if any, contraceptive methods do you use?

8. How many pregnancies have you had? _____
 Number of: Full term _____ Premature _____ Miscarriages _____ Terminations _____ Cesarean _____
 Any complications? _____

9. Have you noted any breast lumps D Yes D No

FOR MEN ONLY:

- 1.Any problems with having an erection? Yes No
- 2.Have you noticed any growths in your testicles/scrotum? Yes No
- 3.Do you have any penile discharge? Yes No
- 4.Any problems with your urine stream? (starting, stopping, force) Yes No

Habits

- Do you smoke? Yes No How much?
- Did you ever smoke? Yes No
- Do you use drugs? Yes No
- Did you ever use drugs? Yes No
- If you used drugs what? _____ IV Use? Yes No
- Do you drink alcohol? Never Rarely Daily Socially
- Are you on a special diet? Yes No What diet?
- How much caffeine do you drink? _____
- How often do you exercise? _____
- What exercises do you do?
- Do you ride a bike? Yes No
- Do you wear a helmet? Always Sometimes Never
- Do you drive a car? Yes No
- Do you wear a seatbelt? Always Sometimes Never
- Do you own a firearm? Yes No • Any partners who practiced risky sex?
- Have you ever been abused? Yes No Yes No
- Do you sunbathe? Yes No • Have you ever had a blood transfusion?
- Do you use tanning booths? Yes No Yes No
- Do you use sunscreen? Yes No • Have you ever been forced to have sex against your
- Do you practice safe sex? Yes No will? Yes No
- Have you had several sex partners? .. Yes No • Do you regularly check your breasts (female)/
testicles (males) for lumps? Yes No

Check here if you have any health concerns not addressed above and/or you would like to discuss privately.

Family History

For your family members below, follow the line across the page and mark an X in those boxes which indicate any illness they have ever had ..

	Alcohol Abuse	Depression	Diabetes	Heart Disease	Hypertension	Stroke	Chronic Lung Disease	Chronic Kidney Disease	Chronic Pain	Chronic Infection	Chronic Illness	Other	Age	Gender	Comments
Father															
Mother															
Brother															
Sister															
Spouse or Significant other															
Children															

(For Doctor: Place Genogram Below)