Medical History

Name:			DOB:	Age:
PERSONAL H	STORY (Please check past or pl	resent history of the foll	owing conditi	ons)
Past Present		Past		Condition
	AIDS/HIV			Heart Murmur
[] []		[]	[]	
[] []	Alcohol/Drug Problems	[]	[]	Hemorrhoids
[] []	Anemia/Low blood counts	[]	[]	Hepatitis
[] []	Asthma	[]	[]	Hiatal Hernia
ii ii	Blood clots in legs	įj	įj	Inguinal Hernia
				High Blood Pressure
[] []	Cancer (type:		[]	
[] []	Cataracts	[]	[]	High Cholesterol
[] []	COPD/Emphysema	[]	[]	Infertility
[] []	Depression/Anxiety	[]	[]	Kidney/Bladder problems
ii ii	Diabetes (sugar)	įj	i i	Liver disease/Jaundice/Hepatitis
ti ti	Easy Bleeding	įj	į	Osteoarthritis
[] []	Eating Disorder (anorexia/b	,	[]	Pneumonia
[] []	Eczema	[]	[]	Rheumatoid Arthritis
[] []	Genital Herpes	[]	[]	Rheumatic Fever
	Genital Infections	[]	[]	
	(chlamydia/gonorrhea)			Seizures/Fits/Epilepsy
r 1 - r 1			r 1	Cariava Iniver/Cariava Assidant
	Genital warts/HPV	L I	[]	Serious Injury/Serious Accident
[] []	Glaucoma	[]	[]	Skin Cancer
[] []	Gout	[]	[]	Stomach Ulcer
Î Î	Hay Fever/Pollen Allergy	[]	[]	Stroke
ii ii	Headaches	[]	į	Transfusion (year)
	Hearing Loss			
[] []	0	[]	[]	Tuberculosis (TB)
[] []	Heart Attack/Heart Disease	e []	[]	Other (specify)
[] []	Hypothyroid (Low thyroid)	[]	[]	Other (specify)
SURGERY/HO	SPITALIZATION/ACCIDENT	S/INJURY HISTORY	list anv surg	eries/ hospitalizations/injuries and the year.
	ditions Requiring Hospitalizat		, , , , , , , , , , , , , , , , , , , ,	Year
00010110113/001		ion/Accident/injury		i cai
Men Only (Plea	ase check any of the following sym	ntoms that apply to you)	
	ase check any of the following sym			Condition
Past Present	Condition	Past	Present	Condition
Past Present	Condition Loss of sexual function	Past []	Present []	Prostate trouble
Past Present	Condition	Past	Present	
Past Present [] [] [] []	Condition Loss of sexual function Discharge from penis	Past [] []	Present [] []	Prostate trouble Sexually transmitted disease
Past Present	Condition Loss of sexual function	Past []	Present [] []	Prostate trouble
Past Present [] [] [] [] [] [] [] []	Condition Loss of sexual function Discharge from penis Lump in testicles	Past [] [] []	Present [] [] []	Prostate trouble Sexually transmitted disease
Past Present [] [] [] [] [] [] [] [] [] [] Women Only (Condition Loss of sexual function Discharge from penis Lump in testicles	Past [] [] [] symptoms that apply to	Present [] [] [] [] [] [] []	Prostate trouble Sexually transmitted disease Surgery on private parts
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Past Present [] [] [] [] [] [] [] [] [] [] Women Only (Condition Loss of sexual function Discharge from penis Lump in testicles Please check any of the following s Condition Bleeding between periods Heavy Periods	Past [] [] [] symptoms that apply to	Present	Prostate trouble Sexually transmitted disease Surgery on private parts Condition Abnormal Pap Smear Breast discharge
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REVIEW OF SYMPTOMS	(Please check any of the following symptoms that apply to you).
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REVIEW OF SYMPTOMS (Please check any of the following symptoms that apply to you).					
Past	Present	Symptom	Past	Presen	t Symptom
[]	[]	Weight change (unexpected)	[]	[]	Trouble swallowing
[]	[]	Fever	[]	[]	Heartburn
[]	[]	Chills	[]	[]	Constipation
[]	[]	Fatigue	[]	[]	Diarrhea
[]	[]	Night Sweats	[]	[]	Blood in stool
[]	[]	Trouble sleeping	Ĩ Ì	[]	Black, tarry stool
įj	[]	Appetite change	i i	i i	Pencil-thin stool
[]	įj	Headache	ΪÌ	įj	Hemorrhoids
[]	[]	Visual change	i i	įj	Jaundice
[]	i i	Hearing loss	i i	ij	Nausea/Vomiting
[]	įj	Earache	ΪÌ	ij	Stomach pain which:
i i	[]	Ringing in ears	įj	i i	Occurs after a meal
ii	i i	Nosebleeds	įj	ii	Occurs with eating greasy, fried food
[j	įj	Sinus problems	ii	įj	Awakens you at night
l i i	i i	Bleeding gums	ii	ii	Is relieved by antacids
ii	i i	Hoarseness	i i	ii	Seasonal/Environmental allergies
ii	i i	Sore throat	i i	ii	Red, itchy eyes
i i	ii	Shortness of breath:	ii	i i	Easy bruising
įj	įj	When doing usual work	įj	ij	Rash
įj	įj	When climbing a flight of stairs	įj	ij	Change in moles
i i	įj	Which awakens you at night	įj	ij	Itchy skin
[]	[]	Cough	įj	ij	Burning when urinating
i i	i i	Coughing up blood	įj	ij	Blood in urine
i i	i i	Wheezing	i i	ij	Frequent urination
i i	įj	Chest pain or tightness:	įj	įj	Trouble holding urine
ii	i i	When walking fast or up hill	įj	įj	Frequent nighttime urination
i i	i i	After a heavy meal	įj	i i	Muscle pain
i i	ii	When upset or excited	ii	i i	Joint pain
l i i	ii	That radiates down your arm	ii	i i	Numbness
l i i	ii	That disappears when you rest	ii	ii	Weakness
i i	ii	Irregular heartbeat	įj	ij	Seizures
l i i	į	Swelling of ankles	įj	įj	Fainting
l į į	įj	Anxiety	įj	ij	Depression
i i	ii	Stress			•
IMMU	IMMUNIZATIONS: Tetanus Booster: Last pneumonia vaccine: Last flu vaccine:				
PERSONAL HABITS					
		drink alcohol?		Yes N	lo If yes, what amount?
		cups of caffeinated beverages per d	ay?		lo If yes, what amount?
	u smoke?		-		lo If yes, how many packs per day?
					If yes, how many years?
Are yo	ou a former	smoker?		Yes N	lo If yes, how many packs per day?
					If yes, how many years?
Have	you ever u	sed street drugs?		Yes N	lo If yes, what type?
		/ using street drugs?			lo If yes, what type?
· · · · · ·					· · · · · · · · · · · · · · · · · · ·

Are you currently using street drugs? FAMILY HISTORY

Relative	Age	If deceased, age of death	Medical Problems/Cause of death

<u>MEDICATIONS</u> Please list the medications, dosages, and frequencies that you currently use. Please include over-the-counter and herbal medications. If you already have a list that you would like us to copy, let the receptionist know and write "see attached sheet" below.

Medication	Dosage	Frequency

Patient Signature

Date

Physician Signature

Date

Review Date:_