PATIENT HISTORY **TODAY'S DATE: __/___/___**

PATIENT NAME: _____ **D.O.B.:** ____/____/____

ALLERGIES: None Known Penicillin Sulfa Codeine Morphine Iodine/Fish Latex Other:_____

List any **SURGERIES**: _____

Have you been diagnosed in the past with the following? (Please CIRCLE YES or NO for each item)

GENERAL:
1. Weight Loss (_____ lbs) YES NO
2. Diabetes YES NO
3. Other _____

PULMONARY:
1. Asthma YES NO
2. COPD YES NO
3. Pneumonia YES NO
4. Bronchitis YES NO
5. Other _____

CARDIOVASCULAR:
1. Hypertension YES NO
2. CAD/prior heart attack YES NO
3. Heart murmur YES NO
4. Heart failure YES NO
5. Atrial fibrillation YES NO
6. Other _____

PSYCHIATRIC:
1. Anxiety YES NO
2. Depression YES NO
3. Other _____

EYES/EARS/NOSE/THROAT:
1. Glasses/Contacts YES NO
2. Cataracts YES NO
3. Glaucoma YES NO
4. Hearing Loss YES NO
5. Other _____

GASTROINTESTINAL:
1. Heartburn/GERD YES NO
2. Hepatitis/Jaundice YES NO
3. Diverticulitis YES NO
4. Colitis YES NO
5. Pancreatitis YES NO
6. Gall Bladder disease YES NO
7. Other _____

GENITOURINARY:
1. Frequent UTIs YES NO
2. Blood in urine/hematuria YES NO
3. Kidney failure YES NO
4. Kidney stones YES NO
5. Other _____

HEMATOLOGIC:
1. Anemia YES NO
2. Mononucleosis YES NO
3. Blood clots YES NO
4. Sickle Cell YES NO
5. Other _____

MUSCULOSKELETAL:
1. Gout YES NO
2. Arthritis YES NO
3. Fracture YES NO
4. Other _____

NEUROLOGIC
1. Stroke YES NO
2. Seizures YES NO
3. Migraine Headaches YES NO
4. Other _____

FEMALE HISTORY:
1. Vaginal bleeding YES NO
2. Pregnancy problems YES NO
3. Breast Lumps / Biopsies YES NO
4. Age when first menses _____ y/o
5. Age when first delivery _____ y/o
6. Other _____

MALE HISTORY:
1. Prostate Issues YES NO
2. Testicular Problems YES NO
3. Low Testosterone YES NO
4. Other _____

Do you have a FAMILY HISTORY of: (Please **MARK**; if yes explain)

CANCER OF:
BREAST or COLON YES ☐ NO ☐ EXPLAIN _____
OTHER CANCERS YES ☐ NO ☐ EXPLAIN _____
HIGH BLOOD PRESSURE YES ☐ NO ☐ EXPLAIN _____
HEART DISEASE/STROKE YES ☐ NO ☐ EXPLAIN _____
DIABETES YES ☐ NO ☐ EXPLAIN _____
MENTAL ILLNESS/SUICIDE YES ☐ NO ☐ EXPLAIN _____

PLEASE TURN OVER AND COMPLETE OTHER SIDE

PATIENT NAME: _____ **Today's Date**: ____/____/____

Please list all current **MEDICATIONS** (including ASPIRIN, VITAMINS, etc). (Refer to containers if necessary)

_____

_____

Please list your **occupation**(s): _____ or **Retired** or **Disabled**

Marital status: married partnered single divorced widowed

Sexual Orientation: heterosexual LGBT

COFFEE/TEA	YES	NO		_____ cups/day
TOBACCO	YES	NO	FORMER	_____ packs a day for _____ years
ALCOHOL	YES	NO	FORMER	_____ drinks a week
OTHER DRUGS	YES	NO	FORMER	(specify) _____

HEIGHT _____ **WEIGHT** _____ lbs

In the past 2 months, have you had any of the following (please indicate approximate date)

GENERAL:

1. Weight Loss (_____ lbs)	YES	NO
2. Fever	YES	NO
3. Night Sweats	YES	NO
4. Fatigue	YES	NO
5. Snoring/Apneas at night	YES	NO
6. Other _____		

CARDIOVASCULAR:

1. Irregular Heart Beats	YES	NO
2. Chest Pain	YES	NO
3. Swelling of Feet	YES	NO
4. Difficulty breathing with exercise	YES	NO
5. Other _____		

EYES/EARS/NOSE/THROAT:

1. Blurry vision	YES	NO
2. Congestion	YES	NO
3. Sore throat	YES	NO
4. Hearing Loss	YES	NO
5. Bleeding gums	YES	NO
6. Other _____		

GASTROINTESTINAL:

1. Heartburn	YES	NO
2. Nausea/Vomiting	YES	NO
3. Diarrhea	YES	NO
4. Constipation	YES	NO
5. Other _____		

GENITOURINARY:

1. Burning with urination	YES	NO
2. Frequent urination	YES	NO
3. Blood in urine	YES	NO
4. Other _____		

MUSCULOSKELETAL:

1. Muscle Aches	YES	NO
2. Joint Aches	YES	NO
3. Other _____		

NEUROLOGIC:

1. Headaches	YES	NO
2. Weakness or numbness	YES	NO
3. Memory problems	YES	NO
4. Other _____		

PULMONARY:

1. Wheezing	YES	NO
2. Shortness of Breath	YES	NO
3. Coughing	YES	NO
4. Other _____		

SKIN:

1. Rash	YES	NO
2. New or changing moles	YES	NO
3. Other _____		

FEMALE:

1. Irregular periods	YES	NO
2. Last menstrual period _____		
3. Breast Lump	YES	NO
4. Vaginal discharge/irritation	YES	NO
5. Other _____		

MALE:

1. Weak urinary stream	YES	NO
2. Erectile dysfunction	YES	NO
3. Testicular mass or pain	YES	NO
4. Other _____		

PATIENT SIGNATURE _____

Revwd: _____	Date: _____
Revwd: _____	Date: _____