

CONSTITUTIONAL SYMPTOMS

Good general health lately No Yes
Recent weight change No Yes
Fever No Yes
Fatigue No Yes
Headaches No Yes

EYES

Eye disease or injury No Yes
Wear glasses/contact lens No Yes
Blurred vision No Yes
Glaucoma No Yes

EARS/NOSE/MOUTH/THROAT

Hearing loss or ringing No Yes
Earaches or drainage No Yes
Chronic sinus problem or rhinitis No Yes
Nose bleeds No Yes
Mouth sores No Yes
Bleeding gums No Yes
Bad breath or bad taste No Yes
Sore throat or voice change No Yes
Swollen glands in neck No Yes

CARDIOVASCULAR

Heart trouble No Yes
Chest pain or angina pectoris No Yes
Palpitation No Yes
Shortness of breathe with walking No Yes
Swelling of feet, ankles or hands No Yes

RESPIRATORY

Chronic or frequent coughs No Yes
Spitting up blood No Yes
Shortness of breathe No Yes
Asthma or wheezing No Yes

GASTROINTESTINAL

Loss of appetite No Yes
Change in bowel movements No Yes
Nausea or vomiting No Yes
Frequent diarrhea No Yes
Painful bowel movements or constipation No Yes
Rectal bleeding or blood in stools No Yes
Abdominal pain or heartburn No Yes
Peptic ulcer (stomach or duodenal) No Yes

GENITOURINARY

Frequent urination No Yes
Burning or painful urination No Yes
Blood in urine No Yes
Change in force or strain when urinating No Yes
Incontinence or dribbling No Yes
Kidney stones No Yes
Sexual difficulty No Yes
Male - testicle pain No Yes
Female - pain with periods No Yes
Female - irregular periods No Yes
Female - vaginal discharge No Yes
Female - # pregnancies ___ # miscarriages ___
Female - date of last Pap smear _____

MUSCULOSKELETAL

Joint pain No Yes
Joint stiffness or swelling No Yes
Weakness of muscles or joints No Yes
Muscle pains or cramps No Yes
Back pain No Yes
Cold extremities No Yes
Difficulty in walking No Yes

INTEGUMENTARY (skin, breast)

Rash or itching No Yes
Change in skin color No Yes
Change in hair or nails No Yes
Varicose veins No Yes
Breast pain No Yes
Breast lump No Yes
Breast discharge No Yes

NEUROLOGICAL

Frequent or recurring headaches No Yes
Light headed or dizziness No Yes
Convulsions or seizures No Yes
Numbness or tingling sensations No Yes
Tremors No Yes
Paralysis No Yes
Stroke No Yes
Head injury No Yes

PSYCHIATRIC

Memory loss or confusion No Yes
Nervousness No Yes
Depression No Yes
Insomnia No Yes

ENDOCRINE

Glandular or hormone problem No Yes
Thyroid disease No Yes
Diabetes No Yes
Excessive thirst or urination No Yes
Heat or cold intolerance No Yes
Skin becoming dryer No Yes
Change in hat or glove size No Yes

HEMATOLOGIC/LYMPHATIC

Slow to heal after cuts No Yes
Bleeding or bruising tendency No Yes
Anemia No Yes
Phlebitis No Yes
Past transfusion No Yes
Enlarged glands No Yes

Use of alcohol:

Never
 Rarely
 Moderately
 Daily

Use of tobacco:

Never
 Previously, but quit
 Current pack daily

Use of Drugs: Never

Type/Frequency: _____

Please list all previous surgeries you have had and the surgery dates:

Please list all medications you take and the dosage:

FAMILY MEDICAL HISTORY:

Is your father living? Yes No If yes, how is his health? Poor Fair Good

What is his age? _____ Any Illness(es)? _____

If he's deceased, what was his age and cause of death? _____

Is your mother living? Yes No If yes, how is her health? Poor Fair Good

What is her age? _____ Any Illness(es)? _____

If she's deceased, what was her age and cause of death? _____

Do you have children? Yes No How many are living? _____

Are any deceased? Yes No If yes, how many are deceased? _____

What is the general health status of your living children? (list any illnesses) _____

What was the age(s) and cause of death or any deceased children? _____

Do you have any brothers? Yes No * If yes, please answer the following?

How many are living? _____ How many are deceased? _____

Please indicate the general health status of each living brother: (i.e. If you have three brothers and two are in good health and one is in fair health, you would write: Two in good health, one in fair health):

* If any suffer from illness, please list the illness:

If any brothers are deceased, please indicate their age and cause of death:

Do you have any sisters? Yes No * If yes, please answer the following?

How many are living? _____ How many are deceased? _____

Please indicate the general health status of each living sister: (i.e. If you have three sisters and two are in good health and one is in fair health, you would write: Two in good health, one in fair health):

* If any suffer from illness, please list the illness:

If any sisters are deceased, please indicate their age and cause of death:

Patient Signature: _____ Date: _____

Physician Signature: _____ Date: _____