

Date \_\_\_\_\_

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_ Sex (Circle One): M F

**Medications** Are you currently taking any treatment (like allergy shots) or medications (including non-prescription)? Yes  No   
If yes, please list \_\_\_\_\_

**Allergies** Are you allergic to any medications or other substances? Yes  No   
If yes, please list \_\_\_\_\_

**Medical Treatment/Surgeries**

Please list any times and reasons you have been in the hospital. Please include any surgeries (*inpatient and outpatient*).

**Family History**

We are especially interested in any history of tuberculosis, diabetes, cancer, leukemia, high blood pressure, stroke, heart or kidney disease, mental illness or attempted suicide. Please fill out the family history chart below:

	Age(s) if living	Age(s) at death	State of health or cause of death
FATHER			
MOTHER			
BROTHER(S)			
SISTER(S)			
SPOUSE			
CHILDREN			

**Screening/Immunizations** If you have had any of the following tests or immunizations, please indicate the date they were last done.

Mammogram \_\_\_\_\_ Electrocardiogram (EKG) \_\_\_\_\_  
Flu Vaccine \_\_\_\_\_ TB Skin Test (PPD) \_\_\_\_\_  
Pneumonia Vaccine \_\_\_\_\_ Chest X-Ray \_\_\_\_\_  
Tetanus Shot \_\_\_\_\_ Polio Vaccine \_\_\_\_\_  
Colon Exam (Sigmoidoscopy or colonoscopy) \_\_\_\_\_ Hepatitis B Vaccine \_\_\_\_\_

**Lifestyle**

1. Do you have any condition that requires a special work assignment? Yes  No   
If yes, please explain \_\_\_\_\_
2. Do you currently use tobacco products? Yes  No   
If yes, please write type \_\_\_\_\_, how much per day \_\_\_\_\_ and for how long. \_\_\_\_\_
3. Have you used tobacco products in the past, but quit? Yes  No   
If yes, please write type \_\_\_\_\_, how much per day \_\_\_\_\_ for how long \_\_\_\_\_ and when quit \_\_\_\_\_
4. Do you currently drink alcoholic beverages? If so, how many per week \_\_\_\_\_ Yes  No
5. Did you drink alcoholic beverages in the past, but have quit? Yes  No   
If so, how many per week \_\_\_\_\_ and when quit \_\_\_\_\_
6. Do you exercise regularly? \_\_\_\_\_ Yes  No
7. Do you feel you may have risk factors for HIV infection (AIDS)? \_\_\_\_\_ Yes  No

**Work History**

1. Have you ever had any chemical exposures at work? Yes  No   
If yes, please explain \_\_\_\_\_
2. Have you ever been unable to work for a physical reason or been refused for a job because of your health? Yes  No   
If yes, please explain \_\_\_\_\_
3. Have you ever been awarded a compensation for accident or injury? Yes  No   
If yes, please explain \_\_\_\_\_
4. Have you been rejected or discharged from the military for a medical cause? Yes  No   
If yes, please explain \_\_\_\_\_

**Please complete other side of this form!**

Please **circle** numbers where you have problems and fill in blanks (if applicable).

### General

1. weight change
2. appetite change
3. general well-being
4. difficulty sleeping
5. weakness or fatigue
6. fever
7. other \_\_\_\_\_

### Dermatologic/Blood Disorders

1. skin diseases
2. cancer, tumor or cysts
3. rashes
4. discoloration, pigmentation changes
5. dry skin
6. bruises easily
7. easy bleeding or hard to stop
8. sweating
9. itching
10. hair problems
11. nail problems
12. other \_\_\_\_\_

### Endocrine & Metabolic

1. sugar diabetes/high blood sugar
2. goiter
3. thyroid problem
4. sterility
5. cholesterol/lipid problem
6. hair loss
7. other \_\_\_\_\_

### Eyes

1. change in vision
2. eye itching, burning or tearing
3. glasses/contacts
4. red eye
5. eye injury, infection or pain
6. glaucoma
7. light sensitivity
7. other \_\_\_\_\_

### Ears

1. infections
2. earaches
3. loss or decreased hearing
4. buzzing or ringing
5. mastoid problems
6. dizziness and nausea
7. ear pain or discharge
8. other \_\_\_\_\_

### Nose, Throat & Mouth

1. sinusitis/nasal stuffiness
2. nose bleeds
3. sore throat
4. hoarseness/voice change
5. tonsillitis
6. taste change
7. dental/gum disease, pain or bleeding
8. other \_\_\_\_\_

### Pulmonary

1. shortness of breath
2. chronic/recurrent cough/cold
3. coughing of blood
4. sputum
5. tuberculosis
6. emphysema or chronic bronchitis
7. asthma/wheezing
8. night sweats
9. pneumonia
10. other \_\_\_\_\_

### Cardiovascular

1. shortness of breath
2. chest pain or pressure
3. palpitation/pounding heart
4. heart attack
5. heart failure
6. swelling feet/ankles
7. high blood pressure
8. leg cramps when walking
9. varicose veins
10. other \_\_\_\_\_

### Gastrointestinal

1. heartburn/indigestion/reflux
2. difficulty swallowing
3. stomach/abdominal pain
4. ulcers
5. vomiting of blood
6. nausea/vomiting
7. frequent diarrhea
8. frequent constipation
9. change in bowel habits
10. rectal bleeding
11. hemorrhoids/rectal disease
12. black bowel movements/blood in stool
13. frequent laxative use
14. jaundice or hepatitis
15. liver trouble/disease
16. other \_\_\_\_\_

### Genito-Urinary

1. burning/painful urination
2. frequent urination
3. difficulty starting urine
4. wetting bed or pants
5. bloody urine
6. kidney stones/infection
7. prostate trouble
8. sexual difficulties
9. venereal disease
10. other \_\_\_\_\_

### Musculoskeletal

1. joint pain or disease
2. joint swelling or warmth
3. joint stiffness
4. muscle pain
5. neck or back injury or pain
6. weakness
7. foot problems
8. other \_\_\_\_\_

### Neurologic

1. frequent and/or severe headaches
2. dizziness
3. blackouts
4. numbness and tingling
5. paralysis
6. convulsions/seizures/epilepsy
7. muscle weakness
8. other \_\_\_\_\_

### Psychiatric

1. anxiety/nervousness
2. depression
3. mood swings
4. other illness
5. have seen psychiatrist
6. alcoholism
7. drug abuse treatment/rehab
8. sleep disturbances
9. other \_\_\_\_\_

### Miscellaneous

1. coffee or tea ( \_\_\_\_ cups per day)
2. marijuana or other drug use
3. other \_\_\_\_\_

### Females

1. age at onset of periods \_\_\_\_\_
2. frequency of periods \_\_\_\_\_
3. last menstrual cycle \_\_\_\_\_
4. excessive flow
5. excessive pain
6. vaginal discharge
7. menopause
8. # of pregnancies \_\_\_\_\_
9. # of successful pregnancies \_\_\_\_\_
10. pregnancy complications
11. date of last pap test \_\_\_\_\_
12. other \_\_\_\_\_

### Breasts

1. lumps
2. pain
3. discharge
4. other \_\_\_\_\_

\_\_\_\_\_  
**Patient Signature**

\_\_\_\_\_  
**Date**

Reviewed by...

\_\_\_\_\_  
**Physician Signature**

\_\_\_\_\_  
**Date**