

Name: _____ Date: _____
Date of Birth: _____ Age: _____ Sex: F M
Single Married Partnered Separated Divorced Widowed Children? Y N
Where, when and for what reason did you last receive health care? _____

Please list, in order of importance, **your** health concerns:

1. _____
2. _____
3. _____
4. _____
5. _____

FAMILY HISTORY: Y=Yes N=No P=Past D=Cause of Death

Please indicate if a **family member** has had any of the following. If yes, specify who. Write in a "D" if the condition was a cause of death for this person and at what age.

Anemia	Y	N	P	_____
Asthma/Hay fever	Y	N	P	_____
Cancer	Y	N	P	_____
Diabetes	Y	N	P	_____
Epilepsy	Y	N	P	_____
Glaucoma	Y	N	P	_____
Heart Disease	Y	N	P	_____
Hypertension	Y	N	P	_____
Kidney Disease	Y	N	P	_____
Mental Illness	Y	N	P	_____
Lung Disease	Y	N	P	_____
Stroke	Y	N	P	_____
Substance Abuse	Y	N	P	_____
Venereal Disease	Y	N	P	_____
Other	Y	N	P	_____

CHILDHOOD ILLNESSES: Please indicate if you have had:

Scarlet Fever	Y	N	Diphtheria	Y	N	Chicken Pox	Y	N	Measles	Y	N
Rubella	Y	N	Mumps	Y	N	Rheumatic Fever	Y	N	Polio	Y	N

VACCINATIONS:

Polio	Y	N	Measles	Y	N	Mumps	Y	N	Rubella	Y	N	
Pertussis	Y	N	Diphtheria	Y	N	Hepatitis B	Y	N	Tetanus	Y	N	last Tetanus shot _____

ALLERGIES: Drugs? Foods? Environmental Substances? _____

Have you ever been hospitalized? When and Why? _____

Illnesses: _____

Surgeries: _____

MEDICATIONS: Indicate if you have used any of the following:

Appetite suppressants	Y N	Laxatives	Y N	Tobacco	Y N
Antacids	Y N	Pain Relievers	Y N	Tranquilizers	Y N
Birth Control Pills or Implant	Y N	Sleeping Pills	Y N	Cortisone	Y N
Thyroid Medicine	Y N	Other Hormones	Y N		

PLEASE LIST all prescription drugs, over-the-counter drugs, vitamins or other supplements you are currently taking: _____

PERSONAL HISTORY: Y=Yes N=No P= a condition you have had in the past

SKIN

Acne	Y	N	P	Boils	Y	N	P
Color Changes	Y	N	P	Eczema	Y	N	P
Hives	Y	N	P	Itching	Y	N	P
Lumps	Y	N	P	Moles	Y	N	P
Rashes	Y	N	P	Scaling/flaking	Y	N	P

HEAD

Hair Loss	Y	N	P	Headaches	Y	N	P
Head Injury	Y	N	P	Skull fracture	Y	N	P

EYES

Eye Pain	Y	N	P	Cataracts	Y	N	P
Double Vision	Y	N	P	Dryness	Y	N	P
Glasses or contacts	Y	N	P	Glaucoma	Y	N	P
Impaired Vision	Y	N	P	Tearing	Y	N	P

EARS

Discharges	Y	N	P	Earaches	Y	N	P
Dizziness	Y	N	P	Impaired Hearing	Y	N	P
Ringling	Y	N	P	Trauma to ear	Y	N	P

NOSE & SINUSES

Frequent Colds	Y	N	P	Hay Fever	Y	N	P
Nose Bleeds	Y	N	P	Sinus Pain	Y	N	P
Stiffness	Y	N	P	Persistent Runny Nose	Y	N	P

MOUTH & THROAT

Bleeding Gums	Y	N	P	Difficulty Swallowing	Y	N	P
Dental Cavities	Y	N	P	Frequent Sore Throat	Y	N	P
Hoarseness	Y	N	P	Sore Tongue	Y	N	P
Ulcerations	Y	N	P	Difficulty Speaking	Y	N	

NECK

Goiter	Y	N	P	Lumps	Y	N	P
Pain or Stiffness	Y	N	P	Swollen Glands	Y	N	P
Trauma to Neck	Y	N	P				

RESPIRATORY

Asthma	Y	N	P	Bronchitis	Y	N	P
Cough	Y	N	P	Emphysema	Y	N	P
Difficulty Breathing	Y	N	P	Pain with Breathing	Y	N	P
Pleurisy	Y	N	P	Pneumonia	Y	N	P
Shortness of Breath	Y	N	P	Sputum	Y	N	P
With lying down	Y	N	P	Tuberculosis	Y	N	P
At Night	Y	N	P	Spitting up of Blood	Y	N	P
With Exertion	Y	N	P				

CARDIOVASCULAR

Angina	Y	N	P	Chest Pain	Y	N	P
Dizziness with standing	Y	N	P	High Blood Pressure	Y	N	P
Heart Disease	Y	N	P	Murmurs	Y	N	P
Palpitations/Fluttering	Y	N	P	Pain in Legs on Walking	Y	N	P
Rheumatic Fever	Y	N	P	Swelling of Ankles	Y	N	P

GASTROINTESTINAL

Belching or Passing Gas	Y	N	P	Blood in Stool	Y	N	P
Change in Appetite	Y	N	P	Change in Thirst	Y	N	P
Gall Bladder Disease	Y	N	P	Heartburn	Y	N	P
Hemorrhoids	Y	N	P	Jaundice or Yellow Skin	Y	N	P
Liver Disease	Y	N	P	Ulcers	Y	N	P
Vomiting	Y	N	P	Vomiting of Blood	Y	N	P
Bowel Movements	How often? _____						
Is this a change?	Y	N					

URINARY

Frequent infections?	Y	N	P	Frequency at Night	Y	N	P
Increased Frequency	Y	N	P	Inability to Hold Urine	Y	N	P
Kidney Stones	Y	N	P	Kidney Pain	Y	N	P
Pain on Urination	Y	N	P	Urethral Discharge	Y	N	P

MUSCULOSKELETAL

Joint Pain/Stiffness	Y	N	P	Broken Bones	Y	N	P
Swelling of Joints	Y	N	P	Muscle cramps to spasms	Y	N	P
Arthritis	Y	N	P	Weakness	Y	N	P

PERIPHERAL VASCULAR

Coldness of Hands/Feet	Y	N	P	Varicose Veins	Y	N	P
Deep Leg Pains	Y	N	P	Thrombophlebitis	Y	N	P
Numbness of Hands/Feet	Y	N	P				

NEUROLOGICAL

Dizziness	Y	N	P	Numbness or Tingling	Y	N	P
Fainting	Y	N	P	Loss of Memory	Y	N	P
Seizures	Y	N	P	Paralysis	Y	N	P

ENDOCRINE/BLOOD

Anemia	Y	N	P	Excessive Thirst	Y	N	P
Easy Bleeding or Bruises	Y	N	P	Heat or Cold Intolerance	Y	N	P
Excessive Hunger	Y	N	P				

MENTAL/EMOTIONAL

Anxiety or nervousness	Y	N	P	Excessive Fears	Y	N	P
Depression	Y	N	P	Mood Swings	Y	N	P
Excessive Anger	Y	N	P	Tension	Y	N	P

FEMALE REPRODUCTIVE SYSTEM

Age menses began _____				Birth control	Y	N	P
Average Number of Days _____				What type(s)? _____			
Length of Cycle _____				_____			
Are your cycles regular? Y N P				Number of Pregnancies _____			
Do you have:				Number of Live Births _____			
Painful Menses Y N P				Number of Miscarriages _____			
Pain During Intercourse Y N P				Number of Abortions _____			
Excessive Flow Y N P				Difficulty Conceiving Y N P			
Premenstrual Syndrome Y N P				History of Venereal Disease Y N P			
Menopausal Symptoms Y N P				Are you sexually active? Y N P			
Breasts:				Sexual Difficulties Y N P			
Do you do self exams Y N P				Sexual Preferences:			
Lumps Y N P				Heterosexual ___			
Pain Y N P				Bisexual ___			
Nipple Discharge Y N P				Homosexual ___			

MALE REPRODUCTIVE SYSTEM

Hernias Y N P				Are you sexually active? Y N P			
Testicular Pain Y N P				Sexual Difficulties Y N P			
Testicular Masses Y N P				Sexual Preferences:			
Discharge or Sores Y N P				Heterosexual ___			
Prostate Disease/Pain Y N P				Bisexual ___			
Venereal Disease Y N P				Homosexual ___			

HABITS Do you...

awaken rested Y N				What are your main hobbies/interests? _____
sleep well Y N				_____
average hours of sleep _____				_____
enjoy your work Y N				_____
watch television Y N				_____
How many hours a day? _____				What forms of exercise do you get and how often?
read Y N				_____
How many hours a day? _____				_____
take vacations Y N				_____
Have you been treated for:				_____
drug dependence Y N				_____
alcohol abuse Y N				_____
Do you use: recreational drugs Y N P				_____
alcoholic beverages Y N P				_____