

NAME _____ DOB _____ Age _____ Today's Date _____

• PAST MEDICAL HISTORY

CURRENT MEDICATIONS AND DOSAGES:

Medication	Dosage	Medication	Dosage

WHAT MEDICATIONS ARE YOU ALLERGIC TO AND WHAT KIND OF REACTION DID YOU HAVE?

Do you take herbs or supplements? Yes No Which ones? _____

List all diseases you have or have had in the past?

High Blood Pressure Elevated Cholesterol Cancer Diabetes Thyroid disease Other chronic illnesses

Others _____

HOSPITAL ADMISSIONS/SURGERIES

Year	Hospitalizations/Surgeries	Year	Hospitalizations/Surgeries

• FAMILY HISTORY

Father: Living - Illnesses _____ Mother: Living - Illnesses _____

Deceased – Cause of Death: _____ Deceased – Cause of Death: _____

Age at Death: _____ Age at Death: _____

Has any parent, brother or sister had: (Please indicate which relative)

(A) Colon Cancer Ovarian Cancer Thyroid Cancer Heart Disease (before age 55 if male or age 65 if female)

Colon Polyps Prostate Cancer Breast Cancer Osteoporosis (bone thinning) Melanoma

(B) Stroke Diabetes Bleeding Disorders Alcoholism

Glaucoma Kidney Disease Arthritis Depression

• SOCIAL HISTORY

Occupation _____ Married Single Divorced Widowed # of Children _____

Alcohol _____ drinks per week

Have you ever had problems with alcohol use? Yes No

In the past year have you ever drunk (or used drugs) more than you meant to? Yes No

Have you ever thought you needed to cut down on your drinking (or drug use) during the past year? Yes No

Cigarettes _____ packs per day for _____ yrs. Quit (when?) _____

Snuff _____ per day for _____ yrs

Chewing Tobacco _____ per day for _____ yrs

Coffee/Tea _____ cups per day

Caffeinated Sodas _____ per day

Heterosexual Homosexual

Recreational Drug Use/Substance Abuse (Injections or Other) Yes No Current Past Which Substances? _____

What type of exercise do you do? _____ How often? _____

Name: _____
Date: _____

• REVIEW OF SYMPTOMS

CHECK THE BOX FOR CURRENT PROBLEMS

Your 3 Main Problems: (1) _____ (2) _____ (3) _____

General

- Fatigue/Weakness
- I do not feel rested when I wake up
- I am not satisfied with my sleep
- I am very sleepy during the day
- I fall asleep easily during the day
- Unhappiness
- Depression/Sadness
- Have felt down or hopeless for several months
- Have little interest/joy in usual activities
- Tearfulness
- Feelings of worthlessness
- Concentration difficulty
- Excessive irritability
- Lack of motivation
- Moodiness
- Nervousness/Anxiety
- Always feel ill
- Unexplained fever >100
- Frequent night sweats
- Weight loss - recent
- Weight gain
- Allergies
- Anemia
- Phobias
- Mental Illnesses

Skin

- I have a mole(s) I want you to check
- Changes in moles/unusual moles
- Are you concerned about skin spots/growths?
- Bruise easily
- Rashes
- Hives
- Itching
- Psoriasis
- Dry skin
- Excessive hair growth
- Hair Loss

Ears/Nose/Throat

- Allergy symptoms
- Frequent colds
- Decreased hearing
- Ringing in the ears
- Ear infections - frequent
- Dizzy spells - dizziness
- Nose Bleeds - frequent
- Sinus trouble
- Sore throat - frequent
- Hoarseness - frequent
- I would like allergy testing

Eyes

- Watery eyes
- Itchy eyes
- Eye Pain
- Double or blurred vision
- Other visual disturbances

Lungs

- Pneumonia
- Asthma/Wheezing
- Cough - persistent
- Coughing blood
- Snoring
- Stop breathing/gasp at night
- TB/Positive TB skin test

Heart/Circulation

- Shortness of breath
 - On exertion
 - Lying flat
- Chest Pain or Chest Discomfort
- High blood pressure
- Heart Murmur
- Palpitations/Racing heart
- Irregular pulse
- Fainting spells
- Swollen ankles
- Leg pain with walking
- Varicose veins
- Cold/Numb feet
- Phlebitis – Blood clots

Gastrointestinal

- Change in bowel habits - recent
- Indigestion or heartburn
- Loss of appetite - recent
- Difficulty swallowing
- Persistent nausea/vomiting
- Peptic ulcers
- Swallowing pain
- Abdominal pain
- Diarrhea
- Constipation
- Bloody or tarry stools
- Hemorrhoids
- Gallbladder problems
- Hepatitis/Jaundice
- Require laxative – How often?

Genital/Urinary

- Hernia
- Urine infections - frequent
- Painful urination
- Frequent urination
- Urinary leakage/Incontinence
- Blood in urine
- Overnight urination x 2
- Loss of control of urination
- History of sexually transmitted diseases?
- Are there sexual issues or dysfunctions you want to discuss?
- Loss of interest in sex

Male

- Decrease in force of urination
- Erection problems
- Too rapid ejaculation
- Testicle lumps/swelling

Female

- Pain/Bleeding during or after sex
- Vaginal discharge/itching
- Abnormal Pap smear
- Flushing/Menopause symptoms
- Significant pain/cramps with periods

Breast

- Pain
- Cysts
- Lumps/Nodules
- Nipple discharge
- Biopsy of a nodule/lump

Female Menstrual History

- Age of Onset _____ Reg Irreg Menopause
- Flow: Heavy Moderate Light
- _____ Days of flow _____ Length of cycle
- # of pregnancies _____
- # of live births _____
- # of miscarriages/other _____
- Birth control method _____

Central/Peripheral Nervous System

- Headaches - frequent
- Seizures/convulsions
- Stroke
- Memory loss
- Tremor/Hands shaking
- Dizzy/Lightheaded
- Muscle wasting
- Numbness/Tingling sensations

Musculoskeletal

- Arthritis
- Back pain - recurrent
- Bone pain/fracture
- Gout
- Foot pain

Miscellaneous

- Date of last tetanus booster shot _____
- Have you ever been physically hurt by your partner?
- Yes No
- Blood transfusion before 1992? Yes No
- I want sexually transmitted disease testing Yes No
- I want HIV testing Yes No
- Frequent foreign travel? Yes No

I would like more information on

- Anti-aging skin care products
- Skin care products to improve my skin
- Skin peels/microdermabrasion to improve my skin
- Acne skin care products
- Allergy testing
- Participating in Research Studies

Other

Other diseases or symptoms or concerns

Explanation: _____

Note to MD or PA: Write "P" next to any symptom discussed on Progress Note (P = see PN)