Name ________________________________ DOB ____________________

Age ________ Sex _________ Occupation _______________________

Descent (Race or Nationality) _____________________________________

Were you referred by a physician for this visit? ____

Name and full address of your physician ____

____

Please state briefly the main problem which prompted you to contact us, and the length of time you have had it (if a checkup, state so)

____

____

____

I. Past Medical History:

Have you ever had	No	Yes	Have you ever had	No	Yes	Have you ever had	No	Yes
Measles			Epilepsy			Asthma		
German Measles			Stroke/paralysis			Hay fever		
Mumps			Nervous disorder			Hives		
Scarlet fever			Heart disease/murmur			Skin disorder		
Rheumatic fever			High blood pressure			Chronic bronchial		
Diphtheria			Vein trouble			Peptic ulcer		
Chickenpox			Blood disease/anemia			Ulcerative colitis		
Tuberculosis			Bleeding tendency			Liver disease		
Pneumonia/pleurisy			Kidney disease			Rectal polyp		
Malaria			Kidney/bladder infection			Hemorrhoids		
Amebic infection			Kidney stones			Diabetes		
Intestinal worms			Prostate trouble			Goiter/thyroid problem		
Syphilis			Arthritis/joint trouble			Other glandular trouble		
Gonorrhea			Back trouble			High Cholesterol		
Polio			Ruptured disk/sciatica			Other Medical Problems		
Cancer			Gout			(list below)		

Other Medical Problems (if applicable) ____

Surgical Operations (please give dates)

____

____

Allergies ____

Have you ever had a blood transfusion? If so, when?

____

Immunizations: (please give date of last booster) Smallpox____________________

Polio________________ Tetanus______________________ Typhoid____________________

Other____________________

Name ________________________________ DOB ____________________
Residence or traveled outside the USA (place and dates)
____
____

II. Marital History:

Present Marriage_____________ Years__________ Previous marriages and duration _______________

Health of spouse ______________

Children (if adopted state so)

No. living ________ Sex, Ages, & Health
____

No. deceased_______ Sex, Ages & Cause ____

III. Family History: (blood relatives only)

Father: Living Yes or No Age or Age at Death ______ Present health or cause of Death _______________
Mother: Living Yes or No Age or Age at Death ______ Present health or cause of Death _______________
Brother(s) # Living ______ Present Health # Deceased _____ cause of Death ____________________
Sister(s) # Living ______ Present Health # Deceased ______ cause of Death ____________________

Have any of your blood relatives ever had: (if yes state relationship)

Cancer		Diabetes	
Heart trouble		Kidney disease	
High blood pressure		Peptic ulcer	
Stroke		Bleeding tendency	
Glaucoma		Nervous/mental disease	
Allergy		Tuberculosis	
Migraine		Thyroid trouble	

IV. Social History

Do you use tobacco now? _______ In the past? _____ For how long? _______ Type and amount_________
Daily/Weekly? _____________
Do you drink alcoholic beverages now? ______ In the past? ______ Type and amount? _________
Daily/Weekly? ___________
What hobbies do you have?____
How many hours per week do you work? _________ How often do you take vacation?_________________
Do you get regular exercise? _________ What? ___________________ How often?___________________

V. Review of Systems

Nervous System: Headache___________Paralysis___________Tremors_________Clumsy Gait_________
Any Other Problems____

Eyes: Blurred Vision______Loss of Vision____Double Vision______Discharge________Pain__________
Any Other Problems____

Ear, Nose, Throat: Decreased Hearing_____Pain________Rhinorrhea__________Bleeding_____________
Any Other Problems____

Name ________________________________ DOB ____________________

Heart: Chest Pain_____Shortness of Breath_______ Palpitations_______
Any Other Problems____
Respiratory System: Cough______Sputum_______Blood in Sputum______SOB______Wheezing_______
Any Other Problems____

Stomach & Intestines: Pain_______Diarrhea_______Constipation________Vomiting__________________
Any Other Problems____

Musculoskeletal: Pain________Decrease in function_______
Any Other Problems____

Psychiatry: Depression__________Anxiety_________
Any Other Problems____

Blood: Anemia________ Rash_______
Any Other Problems____

Circulation of Legs: Pain in legs when walking_________Shiny skin___________Hair Loss____________
Any Other Problems____

Genito-Urinary: Any discomfort during urination__________ Burning during urination____________
Increased Frequency of Urination__________Blood in the Urine______________________________
Frothy or Bubbly Urine____________Abnormal Discharge_____________________
Any Other Problems____

Other:____
____
____

If there are any other medical problems not covered in this previous questioner that you would like to discuss, please note in this space. Your physician will discuss them with you at your initial interview.
____
____
____
____
____