

Name: _____ DOB: _____ Date: _____
 Age: _____

Referring Physician: _____ Primary Care Physician: _____

Chief Complaint: _____

Past Medical History

Past Surgical History

_____	_____
_____	_____
_____	_____

Please list allergies of any kind, and include reactions: _____

Present Medications (Please include all prescription and non-prescription medications.)

Name	Dose	Name	Dose
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____

Obstetrical History # of Pregnancies _____ # of Children: _____ Age at first live birth: _____
 Age of menarche: _____ Age of menopause: _____

Social History/Habits Tobacco: Y / N _____ Type _____ Times per day _____
 Exercise: Y/N _____ Times per wk _____ Caffeine: _____
 Alcohol: Y/N _____ Times per wk _____ Street Drugs: Y/N _____

FAMILY HISTORY:

If Living

If Deceased

Relationship	Age	Health			Age at Death	Cause
Father		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
Mother		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
Brother/Sisters		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
M / F		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
M / F		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
M / F		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
M / F		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
M / F		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		

Check if any blood relatives (mother, father, brother, sister, aunt, uncle, grandfather, grandmother) have had any of the following:

	YES	NO		YES	NO		YES	NO
Stroke			Epilepsy			Colitis		
Cancer			Emphysema			Rheumatic Heart		
High Blood Pressure			Bleeding Tendency			Congenital Heart		
Tuberculosis			Heart Attack			Died Suddenly		
Diabetes			Kidney Disease			Heart Failure		
Leukemia			Arthritis					

Adult History Questionnaire

Please check indicating if you have or have had problems with any of the following and describe in the space provided.

GENERAL HEALTH	YES	NO	COMMENTS		YES	NO	COMMENTS
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Females - Menopause	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chills	<input type="checkbox"/>	<input type="checkbox"/>	_____	Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatigue or tiredness	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	MUSCULOSKELETAL			
Unexplained weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>	_____	Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
EYES				Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Disease/Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____	Joint Stiffness/Cramping	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____				
				SKIN/BREAST			
EARS/NOSE/MOUTH/THROAT				Rash or Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____	Change in Skin Color	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ringing in the Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____	Change in Hair/Nail Color	<input type="checkbox"/>	<input type="checkbox"/>	_____
Earaches/Drainage	<input type="checkbox"/>	<input type="checkbox"/>	_____	Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	_____	Breast Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____	Female – Breast Discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mouth Sores	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____	NEUROLOGICAL			
Voice Changes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen Neck Glands	<input type="checkbox"/>	<input type="checkbox"/>	_____	Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Lightheadedness/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
CARDIOVASCULAR				Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____	Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	_____	Tremors	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Head injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irregular or fast heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	_____	Blackout/Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Swelling of Feet/Hands	<input type="checkbox"/>	<input type="checkbox"/>	_____	PSYCHIATRIC			
				Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	_____
RESPIRATORY				Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____	Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Spitting up Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____	ENDOCRINE			
Asthma/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hormone Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
GASTROINTESTINAL				Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Change in Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	_____	Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____	Excessive Urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heat/Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rectal Bleeding/Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>	_____	Dry Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdominal Pain/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Peptic or Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____	HEMATOLOGY/LYMPHATIC			
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Slow to Heal After Cuts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Bleeding or Bruising Tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____
				Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
GENITOURINARY				Past Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	_____	Enlarged Glands	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning/Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	_____	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	_____	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Incontinence or Dribbling	<input type="checkbox"/>	<input type="checkbox"/>	_____				
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____	ALLERGIC/IMMUNOLOGIC			
Sexual Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	_____	Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Male – Testicle Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____	Environmental Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Female – Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>	_____	Latex Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Female - Planning pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	_____				

Reviewed by: _____ Initials / Date _____

Initials / Date _____