

Major Medical Illnesses		
Date	Place	Doctor

FAMILY HISTORY

Please list any diseases which tend to “run in your family” especially high blood pressure, diabetes, heart disease, cancer, gout, asthma, stomach ulcers, arthritis, allergies, epilepsy, tuberculosis, cystic fibrosis, muscle disease, stroke or thyroid disease.

Father’s History

Is your Father? Alive – Age _____ Deceased – Age _____
 What types of health problems if any did he have?

Mother’s History

Is your Mother? Alive – Age _____ Deceased – Age _____
 What types of health problems if any did she have?

Do you have any brothers?

How many? Alive – Ages _____ Deceased – Ages _____
 What types of health problems do/did they have?

Do you have any sisters?

How many? Alive – Ages _____ Deceased – Ages _____
 What types of health problems do/did they have?

If you served in the military:

Were you ill while in the military? Yes No What was the nature of the illness?
 Did you serve overseas? Yes No If yes, where & when?

HABITS

Have you ever smoked cigarettes regularly? Yes No If yes, how many packs per day? (avg)
 How many years? Are you still smoking? Yes No If no, when did you stop?

Do you use snuff or chewing tobacco? Yes No Do you drink alcohol? Yes No

How many beers daily? How many years?
 How many mixed drinks or glasses of wine daily? How many years?

Do you have any drug, nicotine or alcohol habits which concern you? Yes No

Do you regularly use sleeping pills, tranquilizers, or pain killers? Yes No
 If yes, which ones?

Do you currently use marijuana, cocaine or other “recreational” drugs? Yes No

ANIMAL CONTACT

Please list all pets or any other animals which you may have been in contact with in the past year:

REVIEW OF SYSTEMS

Please check any of the following symptoms or problems you are currently experiencing. If the problem has been resolved, leave it blank. If you are unsure, place a question mark (?) by the medical issue.

<p>General</p> <p><input type="checkbox"/> Weight loss</p> <p><input type="checkbox"/> Weight gain</p> <p><input type="checkbox"/> Fatigue</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Night sweats</p> <p>Do you eat a special diet? <input type="checkbox"/>Yes <input type="checkbox"/>No</p> <p>Do you exercise regularly? <input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p>Skin</p> <p><input type="checkbox"/> Recent change in hair distribution</p> <p><input type="checkbox"/> Changes in skin color</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Hair loss</p> <p><input type="checkbox"/> Other _____</p>	<p>Head/Ear/Eyes/Nose/Throat</p> <p><input type="checkbox"/> Diplopia (double vision)</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Hearing loss</p> <p><input type="checkbox"/> Nose bleeds</p> <p><input type="checkbox"/> Sore throat</p> <p><input type="checkbox"/> Other _____</p>
<p>Neck</p> <p><input type="checkbox"/> Neck mass</p> <p><input type="checkbox"/> Neck pain</p> <p><input type="checkbox"/> Neck stiffness</p> <p><input type="checkbox"/> Swollen glands</p> <p><input type="checkbox"/> Other _____</p>	<p>Respiratory</p> <p><input type="checkbox"/> Cough</p> <p><input type="checkbox"/> History of Tuberculosis</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Wheezing</p> <p><input type="checkbox"/> Other _____</p>	<p>Breast/GYN</p> <p><input type="checkbox"/> Breast discharge</p> <p><input type="checkbox"/> Breast swelling <input type="checkbox"/> Breast mass</p> <p><input type="checkbox"/> Breast tenderness</p> <p><input type="checkbox"/> Menses: Last one? _____</p> <p><input type="checkbox"/> # Miscarriage _____</p> <p><input type="checkbox"/> Other _____</p>
<p>Cardiovascular</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> Edema (swelling) _____</p> <p><input type="checkbox"/> Fast/Irregular heartbeat</p> <p><input type="checkbox"/> Orthopnea (trouble breathing while lying down)</p> <p><input type="checkbox"/> Other _____</p>	<p>Gastrointestinal</p> <p><input type="checkbox"/> Abdominal pain</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Constipation/Diarrhea</p> <p><input type="checkbox"/> Reflux</p> <p><input type="checkbox"/> Other _____</p>	<p>Genitourinary</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Dysuria (pain with urination)</p> <p><input type="checkbox"/> Frequency of urination</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Nocturia (excessive urination at night)</p> <p><input type="checkbox"/> History of malignancy (cancer)</p> <p><input type="checkbox"/> Other _____</p>
<p>Musculoskeletal</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Back pain</p> <p><input type="checkbox"/> Joint pain</p> <p><input type="checkbox"/> Other _____</p>	<p>Neurological</p> <p><input type="checkbox"/> Headaches</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Strokes</p> <p><input type="checkbox"/> Other _____</p>	<p>Psychological</p> <p><input type="checkbox"/> Anxiety</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Insomnia</p> <p><input type="checkbox"/> Other _____</p>
<p>Endocrine</p> <p><input type="checkbox"/> Cold intolerance</p> <p><input type="checkbox"/> Heat intolerance</p> <p><input type="checkbox"/> Thyroid problems</p> <p><input type="checkbox"/> Other _____</p>	<p>Hematological</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Easy bleeding</p> <p><input type="checkbox"/> Easy bruising</p> <p><input type="checkbox"/> Other _____</p>	<p>Other</p>

Signature: _____ Date: _____

Reviewed by Physician: _____