FAMILY HISTORY	If any blood relative has any of the following - Please circle and indicate which relative			
1) Epilepsy	6) Thyroid	11) Osteoporosis	16) High Cholesterol	
2) Migraine	7) Hayfever	12) Arthritis	17) Alcoholism	
3) Mental Illness	8) Asthma	13) Heart Disease	18) Hepatitis	
4) Glaucoma	9) Anemia	14) Stroke	19) Cancer	
5) Diabetes	10) Bleeds easily	15) High Blood Pressure		

Hospital Admissions	**YEAR**	**ILLNESS OR OPERATION**

MEDICATIONS – List all those currently taking		**ALLERGIES**
		SUPPLEMENTS
Pharmacy:		

Persons authorized to view my medical records:	**Records authorized to view (Ex: Lab, Doctors Notes, etc…)**

Social History: Please list significant people in your family (phone # if possible)

1) ____________________ 3) ____________________

2) ____________________ 4) ____________________

Do you feel stress in your life? _ No _ Occasional _ Frequent

If yes, what do you feel is the source of your stress? ____________________

What is your occupation? ____________________

Are you exposed to hazards at your occupation? _ No _ Yes If Yes, what? ____________________

Do you smoke? _ No _ Yes , # of packs per day ______ Have you ever used illegal drugs? _ No _ Yes

Do you use alcohol? _ No _ Yes , # of drinks per day ______ Do you wear a seat belt? _ No _ Yes

Patient Signature: Date:

Name: ______________________ Date of Birth: __________ Today's Date: __________
Address: ______________________ City: __________ State: __________
Home Phone # : __________ Work Phone #: __________ Cell Phone / Other #: __________
Date of last: Doctor Visit __________ Dental Visit __________ Eye Exam __________
Name of last: Physician __________ Dentist __________ Eye Doctor __________
Do you see other physicians? _ No _ Yes ______________________
What is the reason for today's visit? ______________________

Medical History – Mark (C) for current problems. Mark (P) for past problems now resolved.

_ Decreased hearing
_ Ringing in ear
_ Ear infections-frequent
_ Dizzy spells _ Fainting
_ Failing Vision
_ Date of last eye exam ______
_ Blurred Vision
_ Nose Bleeds
_ Sinus Trouble
_ Sore Throats - frequent
_ Hoarseness - prolonged
_ Hayfever / Allergies
_ Pneumonia / Pleurisy
_ Bronchitis / Chronic Cough
_ Asthma / Wheezing
_ Shortness of Breath
  _ on exertion _ lying flat
  _ recent _ affects work
_ Chest Pain
_ High Blood Pressure
_ Heart Murmur
_ Edema
_ Irreg. Pulse _ Palpitations
_ Leg Pain – when walking
_ Varicose veins / Phlebitis
_ Cold numb feet
_ Loss of appetite - recent

_ Difficulty swallowing
_ Heartburn _ Peptic Ulcer
_ Arthritis
_ Nausea / Vomiting
_ Gallbladder Problems
_ Jaundice / Hepatitis
_ Irritable bowel syndrome
_ Abdominal pain
_ Bloating / discomfort
_ Diarrhea _ Constipation
_ Diverticulosis
_ Chron's _ Colitis
_ Inflammatory bowel
_ Bloody or tarry stools
_ Hemorrhoids _ Hernia
_ Overactive Bladder
_ Painful Urination
_ Urination Leakage
_ Kidney Stones
_ Urine Infections – freq.
_ Bed wetting
_ Weight loss / gain
_ Anemia _ Bruise easily
_ Blood transfusions
_ Fatigue
_ Headaches
_ Decreased endurance

_ Diabetes
_ Thyroid disease
_ Seizures
_ Stroke
_ Tremors
_ Headaches
_ Numbness
_ Arthritis
_ Bone fracture
_ Joint injury
_ Osteoporosis
_ Back pain
_ Foot Pain _ Gout
_ Rashes _ Hives
_ Psoriasis
_ Eczema
_ Concentration Probs
_ Depression
_ Anxiety
_ Memory loss
_ Suicidal thoughts
_ Phobias
_ Mental illness
_ Sleep problems
_ Sexual problems
_ Excess facial hair
_ Hair loss

Vaccines

_ Tetanus _____
_ Influenza _____
_ Pneumonia _____
_ Hepatitis B _____
_ Hepatitis C _____
_ Pertussis _____
_ MMR _____
_ Tdap _____
_ Meningitis _____
_ Varicella _____

Female Exams
Date of Last:

Pap Test _____
Mammogram _____
Pregnancies (#) _____
# of Births _____

Exams (Male)
Date of Last:

Prostate Exam _____

Date of Last (M& F)

Rectal Exam _____
Cholesterol _____
Hemoccult _____

Notes:

Provider Signature: ______________________ Date Reviewed: ____________