

OPERATIONS

Please list all surgeries including approximate date or year.

Surgery	Diagnosis	Date/Year

MEDICATIONS

Please list your prescribed drugs and over-the-counter drugs, such as vitamins and nutritional supplements including approximate start date.

Name of Drug	Strength	Frequency Taken	Start Date/Year

ALLERGIES

Please list all drug allergies including type of reaction.

Name of Drug	Reaction

FAMILY HEALTH HISTORY

No History of Familial Disease

Relative (i.e. Father, Mother, Uncle, Sister, etc.)	Illness (i.e. Diabetes, Heart Disease, Prostate Cancer, etc.)

PERSONAL HISTORY AND HEALTH HABITS

Marital Status Marital Status: Single Married Divorced Separated Widowed

Religion

Occupation

Physical Activity	<input type="checkbox"/> Non-Ambulatory	<input type="checkbox"/> Walking	<input type="checkbox"/> Strength Training
	<input type="checkbox"/> Limited-Mobility	<input type="checkbox"/> Running	<input type="checkbox"/> Swimming
	<input type="checkbox"/> Inactive	<input type="checkbox"/> Aerobic Training	<input type="checkbox"/> Recreational Activities

Dietary	<input type="checkbox"/> Regular <input type="checkbox"/> Low Fat <input type="checkbox"/> Vegetarian <input type="checkbox"/> Diabetic	<input type="checkbox"/> Renal Failure <input type="checkbox"/> Gluten Free <input type="checkbox"/> Weight Reduction	<input type="checkbox"/> Weight Gain <input type="checkbox"/> Lactose Free <input type="checkbox"/> Other
Advance Directive	<input type="checkbox"/> None	<input type="checkbox"/> Living Will	<input type="checkbox"/> Surrogate
Alcohol Use	<input type="checkbox"/> None		
	<input type="checkbox"/> Drinks/weekly	Duration in years	Date Discontinued
Tobacco Use	<input type="checkbox"/> None		
	<input type="checkbox"/> Cigarette (pks/day)	Duration in years	Date Discontinued
	<input type="checkbox"/> Other (#/day)	Duration in years	Date Discontinued
Drug Use	<input type="checkbox"/> None		
	<input type="checkbox"/> Marijuana (#/day)	Duration in years	Date Discontinued
	<input type="checkbox"/> Cocaine (#/day)	Duration in years	Date Discontinued
	<input type="checkbox"/> Other (#/day)	Duration in years	Date Discontinued
Physicians Use Only – (Notes/Comments)			
REVIEW OF SYSTEMS (Please check all that apply)			
General	<input type="checkbox"/> Anorexia <input type="checkbox"/> Fever <input type="checkbox"/> Weight Loss/Gain	<input type="checkbox"/> Sweats <input type="checkbox"/> Chills <input type="checkbox"/> Headache	<input type="checkbox"/> Malaise <input type="checkbox"/> Fatigue
Eyes	<input type="checkbox"/> Double Vision <input type="checkbox"/> Vision Loss	<input type="checkbox"/> Eye Pain <input type="checkbox"/> Eye Irritation	<input type="checkbox"/> Eye Discharge <input type="checkbox"/> Blurred Vision
Ears, Nose and Throat	<input type="checkbox"/> Decreased Hearing <input type="checkbox"/> Hoarseness <input type="checkbox"/> Ear Infection	<input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Ear pain <input type="checkbox"/> Sore Throat	<input type="checkbox"/> Nose Bleeds <input type="checkbox"/> Pain with Swallowing <input type="checkbox"/> Sinus problems
Cardiovascular	<input type="checkbox"/> Chest Pain <input type="checkbox"/> Chest Pressure	<input type="checkbox"/> Rapid heartbeat <input type="checkbox"/> Irregular heartbeat	<input type="checkbox"/> Peripheral Edema <input type="checkbox"/> Pacemaker
Respiratory	<input type="checkbox"/> Frequent Cough <input type="checkbox"/> Shortness of Breath	<input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma	<input type="checkbox"/> Bloody Sputum
Gastrointestinal	<input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloody Stools	<input type="checkbox"/> Nausea <input type="checkbox"/> Constipation <input type="checkbox"/> Vomiting	<input type="checkbox"/> Tarry Stools <input type="checkbox"/> Indigestion <input type="checkbox"/> Heartburn
Musculoskeletal	<input type="checkbox"/> Back Pain <input type="checkbox"/> Muscle Weakness	<input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint Swelling	<input type="checkbox"/> Neck Pain
Skin	<input type="checkbox"/> Dryness <input type="checkbox"/> Suspicious Lesion	<input type="checkbox"/> Persistent Itching <input type="checkbox"/> Rash	<input type="checkbox"/> Boils/Cysts <input type="checkbox"/> Sores that don't heal
Neurological	<input type="checkbox"/> Dizziness <input type="checkbox"/> Seizures	<input type="checkbox"/> Weakness <input type="checkbox"/> Numbness	<input type="checkbox"/> Tremors
Psychiatric	<input type="checkbox"/> Depression <input type="checkbox"/> Hallucinations	<input type="checkbox"/> Anxiety	<input type="checkbox"/> Memory Loss

Endocrine	<input type="checkbox"/> Cold/Heat Intolerance <input type="checkbox"/> Weight Change	<input type="checkbox"/> Hair Loss	<input type="checkbox"/> Increased Thirst
Hematological and Lymphatic	<input type="checkbox"/> Abnormal Bruising	<input type="checkbox"/> Easy Bleeding	<input type="checkbox"/> Enlarged Lymph Nodes
Allergic and Immunologic	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Itching	<input type="checkbox"/> HIV Exposure
Genitourinary	<input type="checkbox"/> Blood in Urine <input type="checkbox"/> Bladder/Urinary Infection <input type="checkbox"/> Difficulty Voiding <input type="checkbox"/> Flank Pain <input type="checkbox"/> Frequent Urination <input type="checkbox"/> Hesitancy	<input type="checkbox"/> Incomplete Voiding <input type="checkbox"/> Infertility <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Kidney Infection <input type="checkbox"/> Lack of Control <input type="checkbox"/> Leaking of urine	<input type="checkbox"/> Painful Urination <input type="checkbox"/> Sexual Dysfunction <input type="checkbox"/> Slow Stream <input type="checkbox"/> Urgency <input type="checkbox"/> Urinating at Night
Men	<input type="checkbox"/> Penis Discharge <input type="checkbox"/> Prostate Infection <input type="checkbox"/> Penis Sores	<input type="checkbox"/> Abnormal lumps in scrotum <input type="checkbox"/> Erection Difficulties <input type="checkbox"/> Fertility problems	
Women	<input type="checkbox"/> Abnormal Pap Smear <input type="checkbox"/> Vaginal Infections <input type="checkbox"/> Breast Lump <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Nipple Discharge	<input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> PMS <input type="checkbox"/> Menstrual/Painful Periods	
OB/GYN	<p>Could you be pregnant? Yes <input type="checkbox"/> No <input type="checkbox"/> Date of last period ____/____/____</p> <p>Is your menstrual cycle: (Please check one) Normal <input type="checkbox"/> Irregular <input type="checkbox"/> Heavy <input type="checkbox"/> Light <input type="checkbox"/></p> <p>How many children have you had? _____ Number of C-Sections _____</p> <p>Number of Vaginal Deliveries _____ Number of terminations/miscarriages _____</p> <p>Were there any complications? Please explain: _____</p> <p>_____</p> <p>Date of last mammogram ____/____/____</p>		
Physicians Use Only – (Notes/Comments)			
CERTIFICATION			
The above information is true to the best of my knowledge.			
Patient/Legal Guardian/Authorized Person (Signature)		Date	
X			
Patient/Legal Guardian/Authorized Person (Please Print Name)		Relationship If Other Than Patient	

MD Signature _____ Date Reviewed: _____