

Drugs (prescription and over-the-counter, that you are taking now):

Name of drug	Reason for drug	Dose	For how long	Doctor

Allergies (drugs, food, environmental). Please circle any which are life-threatening):

Are you sensitive to chemical smells? _____

List any chemicals, fumes, and dusts etc. that you are or have been repeatedly exposed to:

Medical / Health History:

Primary Care Doctor/Provider (if any): _____ Date last seen: _____

Reason for seeing: _____

Clinic Name: _____ Phone #: _____ Fax #: _____

Address of Clinic: _____

Other Current Health Providers: Type: Phone: Fax:

How would you describe your general health? _____

Date of last full physical exam: _____ Results: normal other _____

Date of last urine test: _____ Results: normal other _____

Date of last blood work: _____ Results: normal other _____

Date of last prostate exam (males): _____ Results: _____

Date of last PAP/pelvic exam (females): _____ Results: _____

Date of last mammogram: _____ Findings: _____

Are you pregnant (females)? _____ If so, how far along are you? _____

When was your last menstrual period (females)? _____ How long are your cycles? _____

Childhood diseases/Immunizations: _____

Outpatient Procedures / Hospitalizations (surgeries/special diagnostic studies):

Type: _____ Date: _____ Reason for procedure/admission: _____ Outcome/Results: _____

Major Illness/Emotional or Physical Trauma/Accidents (not already listed):

Type: _____ Date: _____ Treatment received: _____ Outcome: _____

Family History: Using the following key, designate which family members have had the following. List type where parentheses are present.

M=Mother F=Father B=Brother S=Sister G=Grandparent C=Child

Condition	M	F	B	S	G	C	Condition	M	F	B	S	G	C
Alcoholism							Hearing Loss						
Allergies							Heart Disease						
Anemia							High Blood Pressure						
Arthritis (Rheumatoid)							High Cholesterol						
Arthritis (Osteo)							Hypoglycemia						
Asthma							Kidney Disease						
Auto Immune Disease							Mental Disorder						
Bleeding Tendency							Obesity						
Cancer ()							Stroke						
Cancer ()							Thyroid (low/high)						
Diabetes							Tuberculosis (TB)						
Drug Addiction							Other:()						
Epilepsy							Other:()						
Headache							Other:()						

Social History (please circle, or complete if applicable):

Single Married Divorced Name of spouse/partner: _____

Your Education: _____

Children (names/ages and health or wellness issues): _____

Are you sexually active? **Yes / No** If yes, is it with (circle one): **male female both**

Do you or your sexual partner(s) use any form of contraception? **Yes / No**

What type(s)? _____

Eliminations:

Bowel movement habits

Urine habits

Frequency: (how often) Per day, times per week		Frequency: (how often in 24 hours)	
Color: (black, brown, yellow, green, white)		Color: (dark yellow, lt. yellow, green, colorless)	
Consistency: (hard, formed, soft, watery)		Character: (clear, cloudy, dilute, etc.)	
Any mucus or blood? (which)		Blood or sediment? (which)	
Does stool pass easily?		Any pain, incontinence, other symptoms?	

Digestion: Any stomach upset, bloating, burping, flatulence (gas), nausea, or rectal itching after food? (circle or specify): _____

Review of Systems

Have you suffered from any of the following?

P=Past N=Now

	P	N		P	N		P	N		P	N
Rashes			Hay fever			Hypertension			Abdominal pain		
Lumps			Sinus trouble			Heart murmur			Bloating		
Sores			Chronic colds			Palpitations			Constipation		
Itching/dryness			Dry mouth			Rheumatic fever			Diarrhea		
Hair/nail change			Gums bleed			Breathing trouble			Heartburn		
Anemia			Sore Tongue			Blood in urine			Indigestion		
Easy Bruising			Stiff neck			Urinary infect.			Excess gas		
Slow Healing			Swollen glands			Excess urination			Nausea		
Nose Bleeds			Goiter			Pain on urination			Vomiting		
Headaches			Breast pain			Urination at night			Hemorrhoids		
Head Injury			Breast lumps			Incontinence			Nervousness		
Eye Pain			Discharge			Urinary hesitance			Tension		
Vision change			Excess thirst			STD's (venereal)			Mood changes		
Glaucoma			Cold intolerance			Penile discharge			Muscle pain		
Cataract			Excess sweating			Impotence			Joint pain		
Flashing Lights			Excess hunger			Vaginal Discharge			Back pain		
Hearing Loss			Fatigue			PMS			Stiffness		
Earaches			Cough			Painful periods			Weakness		
Ringling Ears			Spitting blood			Bleed btw periods			Tremors		
Dizziness			Wheezing			Leg cramps			Paralysis		
Ear Infections			Chest pain			Varicose veins			Numbness		

Any thing else we need to know about you?