NAME: _____ **DATE:** _____

(Please circle)

Date of birth: Mo_____/Day_____/Year____ Age:____ **Marital Status:** Single Married Number of Children:_____

Education: HS College Post Grad Separated Divorced Widowed

School currently attending:_____

Description of Occupation: _____

Family Health Problems: Please Circle all that apply

Father:	HTN	Anemia	Diabetes	Cancer	Lipids	Heart Attack	Stroke	None
Mother:	HTN	Anemia	Diabetes	Cancer	Lipids	Heart Attack	Stroke	None
Siblings:	HTN	Anemia	Diabetes	Cancer	Lipids	Heart Attack	Stroke	None
Children:	HTN	Anemia	Diabetes	Cancer	Lipids	Heart Attack	Stroke	None
	Other:							

Allergies: _____

Type of Reaction: _____

Hospitalizations and Operations: Year & Reason for hospitalization

_____

_____

_____

Immunizations: Last Tetanus: _____ **Last Flu Shot:** _____ **Pneumonia Shot:** _____

Did you have the usual childhood shots? _____

Social Information: Smoker _____ packs per day / week (circle one) Years smoked: _____

Former Smoker _____ years quit How much Alcohol? _____

How much caffeine per day? _____

Hobbies: _____ **Social Activities:** _____

Medications: List ALL medications you use, including those without prescriptions.

Name: Reason:

_____

_____

_____

_____

Current Problems: Please circle all that apply.

General	**HEENT**	**Heme/Lymph**	**CVR**	**Neurological**	**Gastrointestinal**	**Genitourinary**
Fever	Headache	Swollen Glands	Palpitation	Loss of sensation	Nausea	Urinary Frequency
Chills	Visual Changes	Anemia	Chest pain	Numbness	Vomiting	Blood in urine
Fatigue	Hearing loss	Excessive Bleeding	Murmur	Weakness	Diarrhea	Painful urination
Wt loss	Ears ringing		Irreg Heart	Dizziness	Blood in stool	Back pain
Wt gain	Eye/Nasal discharge	**Musculoskeletal**	Edema	Fainting	Vomiting blood	Abdominal pain
Night Sweats	Ear pain	Pain		Loss of memory	Abdominal pain	Kidney Stones
Respiratory	Congestion	Stiffness	**Skin**		Gas/Bloating	Prostate problem
Shortness of breath	Sneezing	Swelling	Hives	**Psychological**	Constipation	Painful ejaculation
Wheezing	Nose bleeds	Atrophy	Lesions	Depression	Indigestion	Pain in scrotum
Cough	Tooth/gum pain	Weakness	Bruising	Irritability	Hemorrhoids	Penile pain
Breast	Diff/Painful swallowing	Joint pain	Rash	Insomnia	Change in stools	Penile discharge
Lump	Eye redness/yellowing	Cramps	Dryness	Anger	Reflux	Vaginal discharge
Discharge	Facial Pain		Warts			Painful menstruation
Pain/Tenderness	Sore Throat					Heavy periods

Females: Number of Pregnancies:_____

Age when periods began:_____ Still menstruating: Yes If yes, length of periods? _____ How often?_____

Date of last pap? _____ No If no, when stopped? _____