

1 IDENTIFICATION *This confidential history will be part of your permanent records.

Name _____ First _____ Middle _____ Sex: M F Date of Birth ___/___/___
 Physician _____ Social Security # _____ Date ___/___/___

2 CHIEF COMPLAINT State your main complaint. Example: Pain in abdomen for 7 months.

Symptom _____ Location _____ Duration _____

3 PRESENT ILLNESS Give a complete description of your illness.

Date of first _____ Recently, symptoms _____ More Frequent More Intense Continuous
 Symptoms ___/___/___ have been: Less Frequent Less Intense Periodic
 How did symptom(s) start _____
 How did symptom(s) progress _____
 What brings it on _____ What relieves it _____
 What makes it worse _____ Associated symptoms _____

Medications	Dosage	Frequency	If #2 above is pain, check the one(s) that best describe it.		
			<input type="checkbox"/> Severe	<input type="checkbox"/> Burning	<input type="checkbox"/> Sharp
			<input type="checkbox"/> Moderate	<input type="checkbox"/> Needle-like	<input type="checkbox"/> Dull
			<input type="checkbox"/> Mild	<input type="checkbox"/> Stabbing	<input type="checkbox"/> Gnawing
			<input type="checkbox"/> Continuous	<input type="checkbox"/> Cramping	<input type="checkbox"/> Sudden
			<input type="checkbox"/> Periodic	<input type="checkbox"/> Deep	<input type="checkbox"/> Gradual
			<input type="checkbox"/> Intermittent	<input type="checkbox"/> Superficial	<input type="checkbox"/> Shifting

4 REVIEW OF SYSTEMS Check only the ones you NOW have or have had RECENTLY.

General <input type="checkbox"/> Weakness <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Night Sweats <input type="checkbox"/> Fainting	Skin <input type="checkbox"/> Color Changes <input type="checkbox"/> Nail Changes <input type="checkbox"/> Hair Changes <input type="checkbox"/> Moles <input type="checkbox"/> Rashes <input type="checkbox"/> Itching <input type="checkbox"/> Sores <input type="checkbox"/> Dryness	Head <input type="checkbox"/> Headaches <input type="checkbox"/> Injuries <input type="checkbox"/> Bumps ___/___/___ <input type="checkbox"/> Last Eye Exam <input type="checkbox"/> Glasses <input type="checkbox"/> Contacts <input type="checkbox"/> Cataracts	Eyes <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Glaucoma <input type="checkbox"/> Redness <input type="checkbox"/> Itching <input type="checkbox"/> Burning <input type="checkbox"/> Swelling <input type="checkbox"/> Pain <input type="checkbox"/> Dryness <input type="checkbox"/> Tearing	Ears <input type="checkbox"/> Hard of Hearing <input type="checkbox"/> Deafness <input type="checkbox"/> Ringing <input type="checkbox"/> Discharge <input type="checkbox"/> Earache <input type="checkbox"/> Itching <input type="checkbox"/> Loss of Balance <input type="checkbox"/> Dizziness <input type="checkbox"/> Room Spins	Nose <input type="checkbox"/> Deceased Smell <input type="checkbox"/> Bleeding <input type="checkbox"/> Pain <input type="checkbox"/> Discharge <input type="checkbox"/> Obstruction <input type="checkbox"/> Post Nasal Drip <input type="checkbox"/> Deviated Septum <input type="checkbox"/> Runny Nose <input type="checkbox"/> Sinus Congestion	Mouth <input type="checkbox"/> Bleeding Gums <input type="checkbox"/> Sores <input type="checkbox"/> Dental Problems <input type="checkbox"/> Pain <input type="checkbox"/> Bad Breath <input type="checkbox"/> Loss of Taste <input type="checkbox"/> Dry Mouth <input type="checkbox"/> Ulcers <input type="checkbox"/> Blisters	Throat <input type="checkbox"/> Soreness <input type="checkbox"/> Bad Tonsils <input type="checkbox"/> Hoarseness <input type="checkbox"/> Pain <input type="checkbox"/> Trouble Swallowing <input type="checkbox"/> Recurrent Infections	
Neck <input type="checkbox"/> Neck Enlargement <input type="checkbox"/> Stiff Neck <input type="checkbox"/> Soreness <input type="checkbox"/> Lumps <input type="checkbox"/> Masses	Breasts <input type="checkbox"/> Discharge <input type="checkbox"/> Lumps <input type="checkbox"/> Pain <input type="checkbox"/> Bleeding <input type="checkbox"/> Nipple Changes <input type="checkbox"/> Skin Changes <input type="checkbox"/> Bloatedness	Lungs <input type="checkbox"/> Cough <input type="checkbox"/> Phlegm <input type="checkbox"/> Blood <input type="checkbox"/> Short of Breath <input type="checkbox"/> Wheezing <input type="checkbox"/> Pain <input type="checkbox"/> Congestion <input type="checkbox"/> Inhalant Exposure	Heart <input type="checkbox"/> Murmur <input type="checkbox"/> Palpitations <input type="checkbox"/> Rapid Heartbeat <input type="checkbox"/> Swollen Extremities <input type="checkbox"/> Cold Extremities <input type="checkbox"/> Chest Pain/Pressure <input type="checkbox"/> Varicose Veins <input type="checkbox"/> Blood Clots <input type="checkbox"/> Blue Extremities	Blood <input type="checkbox"/> Anemia <input type="checkbox"/> Low Blood Iron <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Swollen Nodes <input type="checkbox"/> Painful Nodes <input type="checkbox"/> Sugar in Blood <input type="checkbox"/> Red Spots	Gastrointestinal <input type="checkbox"/> Abdominal Pain <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Bloating <input type="checkbox"/> Belching <input type="checkbox"/> Heartburn <input type="checkbox"/> Indigestion <input type="checkbox"/> Irregular Bowl Habits <input type="checkbox"/> Constipation		<input type="checkbox"/> Diarrhea <input type="checkbox"/> Gas <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Hemias <input type="checkbox"/> Poor Appetite <input type="checkbox"/> Food Intolerance <input type="checkbox"/> Bloody Stool <input type="checkbox"/> Black Stool	
Genitourinary <input type="checkbox"/> Urgency <input type="checkbox"/> Incontinence <input type="checkbox"/> Straining <input type="checkbox"/> Back Pain <input type="checkbox"/> Frequent Voiding <input type="checkbox"/> Stones <input type="checkbox"/> Burning <input type="checkbox"/> Bed Wetting <input type="checkbox"/> Bloody Urine			<input type="checkbox"/> Small Stream <input type="checkbox"/> Discharge <input type="checkbox"/> Sores <input type="checkbox"/> Impotence <input type="checkbox"/> Dribbling <input type="checkbox"/> Cloudy Urine Urine Color: _____	Gynecological <input type="checkbox"/> Spotting Between Periods <input type="checkbox"/> Menstrual Cramps <input type="checkbox"/> Spotting After Menopause <input type="checkbox"/> Discharge <input type="checkbox"/> Itching <input type="checkbox"/> Painful Intercourse <input type="checkbox"/> Irregular Periods <input type="checkbox"/> Hot Flashes <input type="checkbox"/> Pain Between Periods			Contraception – Type _____ Age at first period _____ Age at menopause _____ Duration of cycle _____ Duration of flow _____ No. of pregnancies _____ No. of births _____ No. of miscarriages _____ No. of abortions _____	Menstrual Flow: <input type="checkbox"/> Heavy <input type="checkbox"/> Moderate <input type="checkbox"/> Light Last Period ___/___/___ Last Pap Smear ___/___/___ Last Mammogram ___/___/___
Musculoskeletal <input type="checkbox"/> Muscle Pain <input type="checkbox"/> Muscle Weakness <input type="checkbox"/> Muscle Cramps <input type="checkbox"/> Muscle Twitching <input type="checkbox"/> Joint Stiffness <input type="checkbox"/> Joint Pain <input type="checkbox"/> Joint Swelling <input type="checkbox"/> Joint Deformities		<input type="checkbox"/> Injuries <input type="checkbox"/> Tenderness <input type="checkbox"/> Curvature of Spine <input type="checkbox"/> Back Pain <input type="checkbox"/> Hot Joints	Neurological <input type="checkbox"/> Seizures <input type="checkbox"/> Vertigo <input type="checkbox"/> Dizziness <input type="checkbox"/> Hand Trembling <input type="checkbox"/> Loss of Sensation <input type="checkbox"/> Incoordination <input type="checkbox"/> Loss of Facial Expressions		<input type="checkbox"/> Weak Grip <input type="checkbox"/> Paralysis <input type="checkbox"/> Difficulty of Speech <input type="checkbox"/> Tingling <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Numbness	Psychiatric <input type="checkbox"/> Hyperventilation <input type="checkbox"/> Insecurity <input type="checkbox"/> Depression <input type="checkbox"/> Troubled Sleep <input type="checkbox"/> Irritability <input type="checkbox"/> Anxiousness <input type="checkbox"/> Undecidedness <input type="checkbox"/> Timid	<input type="checkbox"/> Hallucinations <input type="checkbox"/> Loss of Memory <input type="checkbox"/> Alcoholism <input type="checkbox"/> Drug Addiction <input type="checkbox"/> Drug Dependency <input type="checkbox"/> Suicidal Thoughts <input type="checkbox"/> Extreme Worry <input type="checkbox"/> Sexual Problems	Endocrine <input type="checkbox"/> Weight Loss <input type="checkbox"/> Weight Gain <input type="checkbox"/> Hoarseness <input type="checkbox"/> Heat Intolerance <input type="checkbox"/> Cold Intolerance <input type="checkbox"/> Breast Changes <input type="checkbox"/> Hair Changes <input type="checkbox"/> Extreme Thirst <input type="checkbox"/> Voice Changes

5 Past Medical History Check only the ones you have had in the PAST.

Past General State of Health: <input type="checkbox"/> Excellent <input type="checkbox"/> Good <input type="checkbox"/> Fair <input type="checkbox"/> Poor					
<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Skin Trouble	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Polio
<input type="checkbox"/> Mumps	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Heart Trouble	<input type="checkbox"/> Parasites	<input type="checkbox"/> Hernia	<input type="checkbox"/> Mental Illness
<input type="checkbox"/> Measles	<input type="checkbox"/> Tonsillitis	<input type="checkbox"/> Varicose Veins	<input type="checkbox"/> Dysentery	<input type="checkbox"/> Sexual Problems	<input type="checkbox"/> Alcoholism
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> Colitis	<input type="checkbox"/> Prostate Problems	<input type="checkbox"/> Depression
<input type="checkbox"/> Allergies	<input type="checkbox"/> Goiter	<input type="checkbox"/> Hypertension	<input type="checkbox"/> Polyps	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Nervous Breakdown
<input type="checkbox"/> Anemia	<input type="checkbox"/> Breast Trouble	<input type="checkbox"/> Stroke	<input type="checkbox"/> Kidney Infections	<input type="checkbox"/> Arthritis	<input type="checkbox"/> Other
<input type="checkbox"/> Cancer	<input type="checkbox"/> Asthma	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Gout	_____
<input type="checkbox"/> Tumor	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Bladder Trouble	<input type="checkbox"/> Migraines	_____
<input type="checkbox"/> Blood Disease	<input type="checkbox"/> Pleurisy	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Epilepsy	_____
<input type="checkbox"/> Leukemia	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Liver Trouble	<input type="checkbox"/> Syphilis	<input type="checkbox"/> Paralysis	_____
Illnesses – Injuries – Operations		Date	Hospital	Treatment	Physician
Immunizations/Vaccinations		Sexual History		Marital History	
<input type="checkbox"/> DPT	<input type="checkbox"/> German Measles	Sexually Active	Yes No	<input type="checkbox"/> Married	<input type="checkbox"/> Single
<input type="checkbox"/> Mumps	<input type="checkbox"/> Red Measles	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Sep.	<input type="checkbox"/> Divorce
<input type="checkbox"/> Smallpox	<input type="checkbox"/> Influenza			<input type="checkbox"/> Widowed	
<input type="checkbox"/> Typhoid	<input type="checkbox"/> Polio				
<input type="checkbox"/> Tetanus	<input type="checkbox"/> MMR				
				Allergies	

6 Family History List any of the diseases in Section 5 which run in your family.

Blood Relatives Only	Age if Living	Age at Death	Cause of Death	State of Health	Illnesses
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

7 Social History List any of the diseases in Section 5 which run in your family.

Current Weight _____		Usual Weight _____		Maximum Weight _____		Minimum Weight _____	
Mental Work		Physical Work		Exercise		Smoking	
<input type="checkbox"/> Heavy	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy	<input type="checkbox"/> Moderate	<input type="checkbox"/> Heavy	<input type="checkbox"/> Moderate	<input type="checkbox"/> Light	<input type="checkbox"/> Current <input type="checkbox"/> Previous
<input type="checkbox"/> Moderate	<input type="checkbox"/> Light	<input type="checkbox"/> Moderate	<input type="checkbox"/> Light	Type(s) _____		No. of packs per day _____	
No. of hours per day _____		No. of hours per day _____		No. of hours per week _____		No. of years _____	
Others _____		No. of years _____					
Caffeine (Coffee, Tea, Cola)		Aspirins		Nutrition - No. of portions per week		Drugs – No. of doses per week	
Cups per day _____	No. of years _____	No. per day _____	No. of years _____	___ Milk	___ Fruits	___ Beef	___ Vitamins
				___ Milk Products (Cheese, Butter)	___ Breads	___ Pork	___ Laxatives
				___ Eggs	___ Cereal	___ Chicken	___ Antacids
				___ Vegetables	___ Fish	___ Shellfish	___ Diet Pills
					___ Liver	___ Sweets	___ Pain Pills
							___ Water Pills
							___ Sleeping Pills
							___ Nerve Pills
							___ Potassium
							___ Nutrasweet
							___ Saccharin
							Others: _____

Date Reviewed ____/____/____ Review By _____

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