Name: ______________________________________ **Date:** _______________

Referring Doctor: ________________________ **Family Doctor:** ___________________

Why are you seeing the doctor today? ________________How long have you had this problem? _______

What improves or worsens the problem/pain?

____

Are there any symptoms that go along with the problem/pain?

____

Is the problem/pain continuous or does it come and go?

____

Describe the pain (sharp/dull, etc.)

____

Have you tried any medicine/treatment for this problem/pain?

____

<u>PAST MEDICAL HISTORY:</u> **Please CIRCLE if you <u>have</u> or <u>have had</u> any of the following diseases or conditions:**

Abnormal EKG	Arrhythmia	Cataracts	Coronary Artery Dis.
Acid Reflux	Arthritis	Cerebrovascular Dis.	Crohn's Disease
Acne	ASHD	Cervical Disc Disease	Deafness
ADD	Asthma	Chicken Pox	Deviated Septum
ADHD	Atherosclerosis	Cholecystitis	Deep vein thrombosis
AIDS	Atrial fibrillation	Cholelithiasis	Depression
Alcoholism	Autoimmune Disorder	Chronic Bronchitis	Diabetes Mellitus
Allergic Rhinitis	Back pain	Chronic Fatigue Syndrome	Diarrhea
Allergies	Barrett's Esophagus	Chronic Liver Disease	Diverticulitis
Alzheimer's Disease	Basal Cell Carcinoma	Chronic Lung Disease	Diverticulosis
Anemia_______________	Benign Prostatic Hypertrophy	Chronic Renal Disease	Dyspepsia
Anesthesia	Bi-polar disorder	Chronic Renal Failure	Ear Infections
Complications	Bladder Infection	Cleft Lip/Palate	Eating Disorder
Aneurysm	Bleeding Disorder	CMT Syndrome	Electrical Injury
Angina Pectoris	Blindness	Colitis	Elevated PSA
Anorexia Nervosa	Bone Fractures	Colon Cancer	Emphysema
Anxiety Disorder	Brain Tumor___________	Colon Condition	Endocarditis
Aortic aneurysm	Bronchitis	Colonic Polyps	Enlarged Heart
Aortic Insufficiency	Bursitis	Congenital Heart Disease	Epilepsy
Aortic Regurgitation	Cardiomegaly	Cong. Heart Failure	Esophageal Cancer
Aortic Stenosis	Cardiomyopathy	Constipation	Exposure to Chemicals

Fibromyalgia
Fibromyositis
Gastric Cancer
GERD
Gestational Diabetes
Mellitus
Glaucoma
Goiter
Gout
Hay Fever
Heart Attack
Heart Block
Heart Disease__________
Heart Murmur
Heart Valve Problem_______
Hemophilia
Hemorrhoids
Hepatitis
Herniated Disc
Hiatal Hernia
HIV
HPV
Hypercholesterolemia
Hyperglycemia
Hyperlipidemia
Hypertension
Hypoglycemia
High Cholesterol
Impaired Glucose Tolerance
Infectious Disease
Inflam. Bowel Disease
Inguinal Hernia
Insulin Resistance
Insomnia

Interstitial Cystitis
Irritable Bowel Disease
Kidney Infection
Kidney Stones
Laryngeal Cancer
Leukemia
Lipid Disorder
Liver Disease
Lumbar Disc Disease
Lung Cancer
Lung Disease___________
Lymphoma
Macular Degeneration
Malaise
Melanoma
Menniere's Syndrome
Mental Illness
Migraine
Mitral insufficiency
Mitral Stenois
Mitral Valve Prolapse
Morbid Obesity
Morton's Neuroma
Multiple Sclerosis
Mumps
Myalgias
Nervous Breakdown
Nephrotic Syndrome
Neuropathy
Obesity
Osteoporosis
Organic Brain Syndrome
Pacemaker
Paget's Disease

Pancreatic Cancer
Pancreatitis
Panic Disorder
Parkinson's Disease
PCO
Peptic Ulcer
Phlebitis
Pericarditis
Pneumonia
Polio
Polycystic Disease
Polycystic Kidney Dis.
Prostate Cancer
Prostatitis, Acute
Prostatitis, Chronic
Prostatitis, NOS
Psoriasis
Pulmonary Embolism
Pylonephritis
Raynaud's Syndrome
Rectal Cancer
Rectal Fissure
Renal Cell Carcinoma
Renal Failure
Rheumatic Fever
Rheumatoid Arthritis
Sarcoidosis
SBE
Scarlett Fever
Sciatic Neuralgia
Scoliosis
Seizure Disorder
Sickle Cell Anemia
Sickle Trait

Skin Cancer
Skin Disease
Sleep Apnea
SLE
Spinal Cord Injury
Spinal Stenosis
Stroke
Suicide Attempt
Tendonitis
Thrombophlebitis
Thyroid Disease_________
Transfusion Reaction
Transfusion Recipient
Transplant Recipient
Tremor
Tuberculosis
Ulcerative Colitis
Urinary Bladder Stone
Urinary Tract
Infections
Varicose Veins
Vascular Headaches
Venereal Disease
Venous Insufficiency
Ventricular Arrhythmia
Vertebral Disc
Disease
Vertigo
Warts
Yeast Infections
Zoster

Other: ____

Name: ____ **Date:** ____________________

SURGICAL HISTORY: **Please CIRCLE if you have had any of the following surgeries and date of surgery:**

Abdominoplasty
Amputation
Angioplasty
Aortic Aneurysm Rep.
Appendectomy
Arthroscopic Surgery
Back Surgery
Bariatric Surgery
Biopsy_____________
Bladder Surgery
Bowel Resection
Brachytherapy
Brain Surgery
Breast Surgery
Breast Reduction
CABG
Carpal Tunnel Surg.:
(R or L or both)
Carotid Artery Surgery
Cataract Surgery:
(R or L or both)
Cervical Spine Surg.
Cholecystectomy
Circumcision
Colon Resection
Colonoscopy
Contigen Implant
Corneal Surgery:
(R or L or both)
Coronary Artery
Stenting
Coronary Artery Surg.
Cosmetic Surgery
Cyst Removal
Cystocele Repair

Cystoscopy
Cystoscopy-Dilation
Cystoscopy-Retrograde
Cystoscopy - Stent
Cysto-TUR
Fulguration
Disc Surgery
Durasphere Implant
Deliveries:
(Vaginal / CSection)
Ear Surgery:
(R or L or both)
EGD
EGD/Dilation
Esophagus
Epididymectomy
ESWL
Eye Surgery:
(R or L or both)
Facial Surgery
Fissurectomy
Foot Surgery:
(R or L or both)
Gastric Banding
Gastric Bypass
Gastric Surgery
Hand Surgery:
(R or L or both)
Heart Surgery
Heart Transplant
Hemorrhoidectomy
Herniorrhaphy
Hip Surgery
Hydrocelectomy
Ilioconduit

Ileostomy
Indigo Laser Surgery
Inferior Vena Cava Filter
Inguinal
Herniorrhaphy
Interstim Implant
Knee Surgery:
(R or L or both)
Laminectomy
Laparoscopy
Laparatomy
Leg Surgery:
(R or L or both)
Liver Surgery
Liver Transplant
Lithotripsy
Lumbar Spine Surgery
Lumpectomy
Lung Surgery
Lymph Node Dissection
Lysis of Adhesions
Mastectomy
Mastoid Surgery
Meatotomy
Myringotomy Tubes
Nasal Surgery
Needle Biopsy
Nephrectomy
Nephrolithotomy
Nissen Fundoplication
Orchiectomy
Orchiplexy
Pacemaker Insertion
Parathyroidectomy
PEG

Penile Implant
PE Tubes
Pilondial Cyst Excision
Plastic Surgery
Prostatectomy
Pyeloplasty
Radical Prostatectomy
Rectocele Repair
Renal Transplant
Rotator Cuff Surgery
Septoplasty
Sinus Surgery
Skin Grafting
Spermatocelectomy
Splenectomy
Stomach Surgery
Thoracic Spine Surg.
Thryoid Surgery
TMJ Surgery
Tonsil Surgery
TUMT Prostate
TUNA Prostate
TUR Prostate
Umbilical Hernia
Ureteroscopy
Vascular Surgery
Varicocelectomy
Vasectomy
Vein Stripping
Ventral Hernia Repair
VLAP
Whipple Procedure

Other:

____

Name: ______________________________ **Date:** ____________________

FAMILY HISTORY: Please CIRLCE and indicate which family member has/had any of the following:

(Mother, Father, Siblings, Grandmother, Grandfather, Uncle, Aunt)

Adopted ____________________
Alcoholism ____________________
Allergies ____________________
Alzheimer's ____________________
Arthritis ____________________
Asthma ____________________
Bedwetting ____________________
Birth Defects (type) ____________________
Bladder Cancer ____________________
Bleeding Disorder ____________________
Breast Cancer ____________________
Cancer (specify) ____________________
Colitis ____________________
Colon Cancer ____________________
Congenital Heart Disease ____________________
Colonic Polyposis ____________________
Crohn's Disease ____________________
Depression ____________________
Diabetes Mellitus ____________________
Emphysema ____________________
Epilepsy ____________________
Glaucoma ____________________
Heart Attack ____________________
Heart Disease ____________________
Hyperlipidemia ____________________
Hypertension ____________________

Kidney Disease ____________________
Laryngeal Disease ____________________
Leukemia ____________________
Liver Disease ____________________
Lung Cancer ____________________
Lymphoma ____________________
Malignant Melanoma ____________________
Mental Illness (specify) ____________________
Migraine ____________________
Multiple Sclerosis ____________________
Obesity ____________________
Osteoporosis ____________________
Ovarian Cancer ____________________
Parkinson's ____________________
Peptic Ulcer ____________________
Prostate Cancer ____________________
Sickle Cell Anemia ____________________
Sickle Cell Trait ____________________
Stroke ____________________
Suicide ____________________
Thyroid Disease ____________________
Tuberculosis ____________________
Ulcerative Colitis ____________________
Uterine Cancer ____________________

Other: ____

SOCIAL HISTORY: Please provide the following information:

Marital Status: Please indicate years

_____ Single ____Married ____Separated ___Divorced ___Widowed ___Life Partner ___Common Law Spouse

Dependants: Please indicate # of each, if you have:

_____Sons _____Daughters ____Stepchildren _____Adopted ____Foster _____Parents _____Grandparents

Employment: Please circle one that applies:

None
Laborer
Driver
Sales
Clerical
Law Enforcement

Administrative
Executive
Professional
Part-Time
Retired
Other: ____________________

Hobbies: Please circle any that apply to you:

None, Aerobics, Walking, Jogging, Running, Golf, Tennis, Computers, Basketball, Football, Swimming,

Soccer, Baseball

Other: ____________________

Name: ______________________________ Date: ____________________

Alcohol Consumption:

_____None _____Yes If Yes, circle Occasional / Moderate / Heavy # of drinks per day ________

Tobacco Use:

_____None _______Yes #________Packs/day ______Cigarettes/day _____Smokeless Tobacco

If you previously stopped, when? ______________________________

Recreational Drugs: _______None If yes, please list: ____

Caffeinated Beverages: _______None If yes, circle Low / Moderate / Excessive

Recent Foreign Travel:

_________None Americas (specify) _____________________Worldwide (specify) _________________________

ALLERGIES – Please list ALL types (Drug, seasonal, pets, environmental foods)

____

____

____

CURRENT MEDICATIONS – Please list ALL medications you are currently taking including over the counter meds

Drug Name:	Strength:	Directions/How you take it:
___________________________	_________________	____
___________________________	_________________	____
___________________________	_________________	____

Pharmacy Name: ____________________________________ Phone #: ____

By what method did you choose our practice:

_______Referring Physician _______Friend ______Yellow Pages ______Insurance Company _____Other

Name: ____ Date: ____________________________

REVIEW OF SYSTEMS: **Please CIRCLE if you have or have had any of the following diseases or conditions:**

Constitutional
Aches and Pains
Easy Bruising
Fever
Chills
Hot Flashes
Night Sweats
Fatigue
Generalized Weakness
Insomnia
Swollen Glands
Anorexia
Weight Loss
Weight Gain

Allergic/Immunologic
Seasonal Allergies
Drug Allergies
Food Allergies
Animal Allergies

Environmental Allergies
Insect Allergies
Bee Sting Allergy
Insect Sting Allergy
Itching
Hives
Lip Swelling
Tongue Swelling

Eyes
Blindness
Blurred Vision
Double Vision
Dry Eyes
Glasses
Eye Pain
Watery Eyes

Ear/Nose/Throat/Mouth
Ear infection
Tinnitus
Hearing Loss
Nosebleeds
Sinus problems
Sore throat
Swallowing Difficulties
Persistent Hoarseness

Cardiovascular
High Blood Pressure
Irregular Heart Beat
Palpitation
Chest Pain
Dyspnea on Exertion
Orthopnea
Low Exercise Tolerance
Edema

Respiratory
Cough
Sputum
Shortness of Breath
Wheezing

Gastrointestinal
Acid Reflux
Indigestion/heartburn
Nausea/Vomiting
Abdominal Pain
Abdominal Cramps
Diarrhea
Constipation
Change in Bowel Habits
Hemorrhoids
Flatulence
Gas
Rectal Bleeding
Tarry Stool

Genitourinary
Painful urination
Urinary Frequency
Nocturia
Polyuria
Urinary Retention
Enuresis
Incontinence
Hematuria (blood in urine)
Dark Colored Urine
Urethral Discharge
Sexual Dysfunction
Penile Lesion
Bedwetting
Dribbling
Burning on Urination
Erection Problems
Premature Ejaculation
Flank Pain
Hesitancy
Kidney Failure
Kidney Infections
Kidney Stones
Prostate Infections
Low Desire
Sexually Transmitted Diseases
Stranguria
Suprapubic Pain
Tests/Scrotal Swelling
Urgency
Urinary Tract Infections
Urologic Cancer
Urologic Surgery
Vaginal Bleeding
Vaginal Discharge/Problems
Weak Stream

Endocrine
Polyuria
Polydypsia
Excessive thirst
Tired/sluggish
Heat intolerance
Cold intolerance

Hematologic Lymphatic
Swollen Glands
Blood clotting problem

Integumentary
Acne
Boils
Persistent Itch
Skin rash
Changing Moles
Pigment Change

Musculoskeletal
Back pain
Joint pain
Neck Pain/Stiffness
Muscle Cramps
Muscle Weakness

Neurological
Headache
Dizzy Spells
Balance Problems
Numbness/Tingling
Burning
Tremors
Leg or Arm Weakness
Memory Loss
Speech Problems

Psychologic
Not satisfied with life
Anxious
Depressed
Considered suicide

Other: ____

Name: ______________________________ **Date:** ______________