

If you are unable to answer any of the questions, please bring it to the doctor's attention. This form becomes part of your medical record and is held in confidence between you and your physician.

Please Print

Name: _____ **Date:** _____
Social History: Place of birth: _____ Marital Status: Single Married Divorced Widowed
 Military Service: Yes No When: _____ Where: _____ Maritime Employee: Yes No
 International travel or lived overseas: Yes No When: _____ Where: _____
 Use of tobacco: Never Previously, but quit Current packs/day _____
 Use of alcohol: Never Rarely Moderate Daily
 Do you use illegal drugs? Never Type/Frequency _____

Family Medical History:

	<u>Age</u>	<u>Diseases</u>	<u>If Deceased, Cause of Death</u>
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Spouse	_____	_____	_____
Children	_____	_____	_____

Previous Surgeries and Hospitalizations:

<u>Date</u>	<u>Hospital</u>	<u>Reason</u>	<u>Physician</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date of last EKG: _____ **Female - date of last pap smear** _____
Date of last chest X-ray: _____ **Female- date of last mammogram** _____
Do you take blood thinner? _____ **Female- date of last menstrual period** _____
Do you take diet pills? _____ **Male- date of last prostate check** _____

CONSTITUTIONAL SYMPTOMS

	No	Yes
Good general health lately	<input type="checkbox"/>	<input type="checkbox"/>
Recent weight change	<input type="checkbox"/>	<input type="checkbox"/>
Fever	<input type="checkbox"/>	<input type="checkbox"/>

MUSCULOSKELETAL

	No	Yes
Joint pain	<input type="checkbox"/>	<input type="checkbox"/>
Joint stiffness or swelling	<input type="checkbox"/>	<input type="checkbox"/>
Weakness of muscle or joints	<input type="checkbox"/>	<input type="checkbox"/>



Name: _____

Date: _____

- Fatigue
- Cancer
- Acute infections
- HIV / Aids
- Hepatitis
- Other Infectious Disease
- Venereal disease
- Hereditary defects

- Muscle pain or cramps
- Back pain
- Cold extremities
- Difficulty in walking
- Arthritis / gout

EYES **No** **Yes**

- Eye disease or injury
- Wear glasses / contact lens
- Blurred or double vision

EARS / NOSE / MOUTH / THROAT **No** **Yes**

- Hearing loss of ringing
- Earaches or drainage
- Chronic sinus problem or rhinitis
- Nose bleeds
- Mouth sores
- Bleeding gums
- Bad breath or bad taste
- Sore throat or voice change
- Swollen glands in neck

CARDIOVASCULAR **No** **Yes**

- Heart trouble
- Chest pain or angina pectoris
- Palpitation
- Shortness of breath when walking or lying flat.
- Swelling of feet, ankles or hands
- Hypertension

RESPIRATORY **No** **Yes**

- Chronic or frequent coughs
- Spitting up blood
- Shortness of breath
- Asthma or wheezing
- Sleep Apnea
- Tuberculosis

GASTROINTESTINAL **No** **Yes**

- Loss of appetite
- Change in bowel movements
- Nausea or vomiting
- Frequent diarrhea
- Painful bowel movements or constipation
- Rectal bleeding or blood in stool
- Abdominal pain or heartburn
- Peptic ulcer (stomach or duodenal)

GENITOURINARY **No** **Yes**

- Frequent urination
- Burning or painful urination
- Blood in urine
- Change in force of strain when urinating
- Incontinence or dribbling
- Kidney stones
- Male - testicle pain
- Female - pain with periods
- Female - irregular periods
- Female - vaginal discharge
- Female - Are you pregnant?
- Female - # pregnancies _____ #
miscarriages _____

INTEGUMENTARY (skin, breast) **No** **Yes**

- Rash or itching
- Change in skin color
- Change in hair or nails
- Varicose veins
- Breast pain
- Breast lump
- Breast discharge

NEUROLOGICAL **No** **Yes**

- Frequent or recurring headaches
- Light headed or dizzy
- Convulsions or seizures
- Numbness or tingling sensations
- Tremors
- Paralysis
- Stroke
- Head Injury

PSYCHIATRIC **No** **Yes**

- Memory loss or confusion
- Nervousness
- Depression
- Insomnia

ENDOCRINE **No** **Yes**

- Glandular or hormone problem
- Thyroid disease
- Diabetes
- Excessive thirst or urination
- Heat or cold intolerance
- Skin becoming dryer
- Change in hat or glove size

HEMATOLOGIC / LYMPHATIC **No** **Yes**

- Slow to heal after cuts
- Bleeding or bruising tendency
- Anemia
- Phlebitis
- Past transfusion
- Enlarged glands

ALLERGIC / IMMUNOLOGIC **No** **Yes**

- History of skin reaction or other adverse reaction to:
- Penicillin or other antibiotics
 - Morphine, Demerol, or other narcotics
 - Novocaine or other anesthetics
 - Aspirin or other pain remedies
 - Tetanus antitoxin or other serums
 - Iodine, methiolate or other antiseptic
 - Other drugs / medications _____
 - Known food allergies _____