

HEALTH HABITS Check (✓) if yes and describe how much you use.

Do you / did you ever drink alcohol?
 No Yes What type? _____ How much per week? _____ For how many years? _____ When did you stop? _____

Do you / did you ever use tobacco?
 No Yes What type? _____ How much per day? _____ For how many years? _____ When did you stop? _____

Do you / did you ever use any other recreational or prescription drugs?
 No Yes What type? _____ How much per day? _____ When did you start? _____ When did you stop? _____

OCCUPATIONAL CONCERNS

Occupation (If retired, please list previous occupations and current activities)

SOCIAL HISTORY

Marital Status (circle one) Single Married Widowed Divorced Number of children living at home: _____

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of health Living and Well	Age at Death	Cause of Death
Father				
Mother				
Brothers				
Sisters				

Check (✓) if your blood relatives have had any of the following:

Disease	Relationship to you	Disease	Relationship to you
<input type="checkbox"/> Arthritis, Gout		<input type="checkbox"/> High Blood Pressure	
<input type="checkbox"/> Asthma		<input type="checkbox"/> Kidney Cancer	
<input type="checkbox"/> Breast Cancer		<input type="checkbox"/> Kidney Disease	
<input type="checkbox"/> Cancer Type: _____		<input type="checkbox"/> Kidney Stones	
<input type="checkbox"/> Chemical Dependency		<input type="checkbox"/> Prostate Cancer	
<input type="checkbox"/> Diabetes		<input type="checkbox"/> Stroke	
<input type="checkbox"/> Heart Disease			

REVIEW OF SYSTEMS Check (✓) symptoms you currently have or have had in the past.

<p>CONSTITUTIONAL Current Past</p> <p>Chills <input type="checkbox"/> <input type="checkbox"/></p> <p>Fever <input type="checkbox"/> <input type="checkbox"/></p> <p>Weight Gain <input type="checkbox"/> <input type="checkbox"/></p> <p>Weight Loss <input type="checkbox"/> <input type="checkbox"/></p> <p>ENDOCRINE Current Past</p> <p>Excessive Thirst <input type="checkbox"/> <input type="checkbox"/></p> <p>Hair Loss <input type="checkbox"/> <input type="checkbox"/></p> <p>Heat / Cold Intolerance <input type="checkbox"/> <input type="checkbox"/></p> <p>ENT Current Past</p> <p>Dental Problems <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficulty Swallowing <input type="checkbox"/> <input type="checkbox"/></p> <p>Loss of Hearing <input type="checkbox"/> <input type="checkbox"/></p> <p>Ringin in Ears <input type="checkbox"/> <input type="checkbox"/></p> <p>Sinus Problems <input type="checkbox"/> <input type="checkbox"/></p> <p>Sore Throat <input type="checkbox"/> <input type="checkbox"/></p> <p>EYES Current Past</p> <p>Blurred Vision <input type="checkbox"/> <input type="checkbox"/></p> <p>Visual Changes <input type="checkbox"/> <input type="checkbox"/></p> <p>GI (Abdominal Symptoms) Current Past</p> <p>Abdominal Pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Bloody Stool <input type="checkbox"/> <input type="checkbox"/></p> <p>Constipation <input type="checkbox"/> <input type="checkbox"/></p> <p>Diarrhea <input type="checkbox"/> <input type="checkbox"/></p> <p>Indigestion <input type="checkbox"/> <input type="checkbox"/></p> <p>Nausea <input type="checkbox"/> <input type="checkbox"/></p> <p>Vomiting <input type="checkbox"/> <input type="checkbox"/></p> <p>HEART Current Past</p> <p>Chest Pain <input type="checkbox"/> <input type="checkbox"/></p> <p>Chest Pressure <input type="checkbox"/> <input type="checkbox"/></p> <p>Rapid/Irregular Heartbeat <input type="checkbox"/> <input type="checkbox"/></p> <p>Swelling of Ankles <input type="checkbox"/> <input type="checkbox"/></p>	<p>GU (Problems with Urination) Current Past</p> <p><input type="checkbox"/> Blood in Urine <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Flank Pain <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Hesitancy <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Incomplete Voiding <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Infertility <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Kidney Stones <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Lack of Control <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Painful Urination <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Slow Stream <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Urgency <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Urinating at Night <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Urinating Often <input type="checkbox"/> <input type="checkbox"/></p> <p>WOMEN ONLY Current Past</p> <p><input type="checkbox"/> Abnormal Pap <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Vaginal Infections <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Breast Lump <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Hot Flashes <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Menstrual Pain <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Nipple Discharge <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Painful Intercourse <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Painful Periods <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Premenstrual Syndrome <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Vaginal Discharge <input type="checkbox"/> <input type="checkbox"/></p> <p>Date of last mammogram? / /</p> <p>MEN ONLY Current Past</p> <p><input type="checkbox"/> Erection Difficulties <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Lump in Testicles <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Penis Discharge <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> Sore on Penis <input type="checkbox"/> <input type="checkbox"/></p>	<p>SEXUALLY TRANSMITTED DISEASES</p> <p><input type="checkbox"/> Specify: _____</p> <p><input type="checkbox"/> Specify: _____</p> <p>HEMAT/LYMPH Current Past</p> <p>Easy Bruising <input type="checkbox"/> <input type="checkbox"/></p> <p>Enlarged Lymph Nodes <input type="checkbox"/> <input type="checkbox"/></p> <p>LUNGS Current Past</p> <p>Cough <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficulty Breathing on Exertion <input type="checkbox"/> <input type="checkbox"/></p> <p>Shortness of Breath <input type="checkbox"/> <input type="checkbox"/></p> <p>Spitting up Blood <input type="checkbox"/> <input type="checkbox"/></p> <p>Wheezing <input type="checkbox"/> <input type="checkbox"/></p> <p>MS (Muscle/Joint/Bone) Current Past</p> <p>Change in Height <input type="checkbox"/> <input type="checkbox"/></p> <p>Difficulty Walking <input type="checkbox"/> <input type="checkbox"/></p> <p><input type="checkbox"/> _____</p> <p>Pain, weakness, numbness in (area) _____</p> <p>SKIN Current Past</p> <p>Dry Skin <input type="checkbox"/> <input type="checkbox"/></p> <p>Moles <input type="checkbox"/> <input type="checkbox"/></p> <p>Rash <input type="checkbox"/> <input type="checkbox"/></p> <p>Sores That Do Not Heal <input type="checkbox"/> <input type="checkbox"/></p> <p>NEUROLOGIC Current Past</p> <p>Dizziness <input type="checkbox"/> <input type="checkbox"/></p> <p>Headaches <input type="checkbox"/> <input type="checkbox"/></p> <p>Memory Problems <input type="checkbox"/> <input type="checkbox"/></p> <p>Numbness <input type="checkbox"/> <input type="checkbox"/></p> <p>Tremor <input type="checkbox"/> <input type="checkbox"/></p> <p>PSYCHIATRIC Current Past</p> <p>Anxiety <input type="checkbox"/> <input type="checkbox"/></p> <p>Depression <input type="checkbox"/> <input type="checkbox"/></p>
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I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____ Reviewed By _____ Date _____