

**Medical Information**

Date \_\_\_\_\_

Name \_\_\_\_\_ Age \_\_\_\_ Birth Date \_\_\_\_\_

Occupation \_\_\_\_\_ Referred by \_\_\_\_\_

Date of Last Physical Exam \_\_\_\_\_ Primary Physician Name \_\_\_\_\_

Primary Physician Address \_\_\_\_\_

Chief Complaint (reasons for coming to doctor):

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Mediations you are allergic to:

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Current Medical Problems:

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Immunizations (date last given): Tetanus \_\_\_\_\_ Pneumonia \_\_\_\_\_

Influenza \_\_\_\_\_ Other \_\_\_\_\_

List Hospitalizations, Operations, and Injuries:			Tests (please give dates):
Year	Reason	Hospital	
			Chest X-Ray _____
			Upper GI Series _____
			Barium Enema _____
			Colonoscopy _____
			CT Scan _____
			MRI _____
			EKG _____

Do you smoke? YES NO # Years \_\_\_\_ # Packs/Day \_\_\_\_ When did you quit? \_\_\_\_\_

Do you drink alcoholic beverages? YES NO Estimated amount/day \_\_\_\_\_

Do you drink coffee? YES NO Tea? YES NO Cups per day \_\_\_\_\_

Specify any foreign travel in the past 10 years \_\_\_\_\_

Food intolerances \_\_\_\_\_

Are you overweight? YES NO By how many pounds \_\_\_\_\_

Exercise/Kind/Times per week \_\_\_\_\_

Family History	Alive	Dead	Age	Medical Problems	Other Relatives' History:
Father					Heart Attacks _____
Mother					Heart Failure _____
Sibling _____					Stroke _____
Sibling _____					Hypertension _____
Sibling _____					Diabetes _____
Spouse					Ulcer Disease _____
Child					Colonic Polyps _____
Child					Colon Cancer _____
Child					Other Cancers _____

PAST MEDICAL HISTORY: Place an (X) in the box in front of a past problem.(AND CURRENT PROBLEMS).

<input type="checkbox"/>	Hypertension	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	Genital Herpes	<input type="checkbox"/>	Anemia
<input type="checkbox"/>	Heart Attacks	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	Nervous Disorders	<input type="checkbox"/>	Bleeding Problem
<input type="checkbox"/>	Heart Failure	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Angina	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Phlebitis
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Rheumatic Fever	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	Kidney Stones
<input type="checkbox"/>	Ulcers Gastric/Duodenal	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	Urinary Tract Inf.
<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	Syphilis	<input type="checkbox"/>	Blood Transfusions	<input type="checkbox"/>	Colitis
<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	Gonorrhea	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	Colonic Polyps

SYSTEMS REVIEW:

<input type="checkbox"/>	Poor Appetite	<input type="checkbox"/>	Nose Bleeds	<input type="checkbox"/>	Difficulty Swallowing
<input type="checkbox"/>	Weight Loss	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	Heart Burn
<input type="checkbox"/>	Weight Gain	<input type="checkbox"/>	Sinus Trouble	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	Ear Infections	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Trouble Smelling	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	Weakness	<input type="checkbox"/>	Frequent Colds	<input type="checkbox"/>	Belly Pain
<input type="checkbox"/>	Fever/Chills	<input type="checkbox"/>	Gum Disease	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>		<input type="checkbox"/>	Constipation
<input type="checkbox"/>	Skin Changes	<input type="checkbox"/>	Frequent Cough	<input type="checkbox"/>	Blood in Stools
<input type="checkbox"/>	Excess Body Hair	<input type="checkbox"/>	Sputum	<input type="checkbox"/>	Black Stools
<input type="checkbox"/>	Heat or Cold Intolerance	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	Vomiting Blood
<input type="checkbox"/>	Poor Concentration	<input type="checkbox"/>	Shortness of Breath	<input type="checkbox"/>	Bloating
<input type="checkbox"/>	Poor Memory	<input type="checkbox"/>	Cough Up Blood	<input type="checkbox"/>	Belching
<input type="checkbox"/>	Early Morning Awakening	<input type="checkbox"/>	Tuberculosis Exposure	<input type="checkbox"/>	Flatulence (Gas)
<input type="checkbox"/>	Depression	<input type="checkbox"/>		<input type="checkbox"/>	Rectal Pain
<input type="checkbox"/>	Crying Spells	<input type="checkbox"/>	Palpitations	<input type="checkbox"/>	Mucus in Stools
<input type="checkbox"/>		<input type="checkbox"/>	Shortness of Breath/Exercise	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	Head Aches	<input type="checkbox"/>	2 or More Pillows	<input type="checkbox"/>	Change in Bowel Habits
<input type="checkbox"/>	Blurred Vision	<input type="checkbox"/>	Ankle Swelling	<input type="checkbox"/>	
<input type="checkbox"/>	Double Vision	<input type="checkbox"/>	Heart Murmur	<input type="checkbox"/>	Frequent Urination
<input type="checkbox"/>	Blind Spots	<input type="checkbox"/>	Fainting	<input type="checkbox"/>	Void at Night
<input type="checkbox"/>	Hearing Difficulty	<input type="checkbox"/>	Enlarged Heart	<input type="checkbox"/>	Burning with Urination
<input type="checkbox"/>	ringing in Ears	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	Hesitancy
<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	Wake Up Short of Breath	<input type="checkbox"/>	Incontinence
<input type="checkbox"/>		<input type="checkbox"/>	Varicose Veins	<input type="checkbox"/>	Blood in Urine
<input type="checkbox"/>	Convulsions	<input type="checkbox"/>	Leg Cramps	<input type="checkbox"/>	Impotence
<input type="checkbox"/>	Loss of Consciousness	<input type="checkbox"/>		<input type="checkbox"/>	
<input type="checkbox"/>	Paralysis	<input type="checkbox"/>	Muscle Weakness	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Numbness	<input type="checkbox"/>	Muscle Pain	<input type="checkbox"/>	Gout
<input type="checkbox"/>	Back Aches	<input type="checkbox"/>	Muscle Spasm	<input type="checkbox"/>	Others

WOMEN:

<input type="checkbox"/>	Irregular Periods	<input type="checkbox"/>	Last Period:
<input type="checkbox"/>	Severe Cramping	<input type="checkbox"/>	Last Pelvic Exam:
<input type="checkbox"/>	Hot Flashes	<input type="checkbox"/>	Last Pap Test:
<input type="checkbox"/>	Vaginal Discharges	<input type="checkbox"/>	Result:
<input type="checkbox"/>	Vaginal Bleeding/Spotting	<input type="checkbox"/>	Last Mammogram:
<input type="checkbox"/>	Breast Lump or Discharge	<input type="checkbox"/>	Result:
<input type="checkbox"/>	Pain with Intercourse	<input type="checkbox"/>	