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Name _____ Age _____ Sex _____

Reason for Visit _____

PAST MEDICAL HISTORY: Check if you have had any of the following:

_____asthma
_____bronchitis
_____pneumonia
_____anemia
_____blood clot
_____sugar (diabetes)
_____radiation treatments
_____hemorrhoids
_____cancer
_____epilepsy or fits
_____glaucoma
_____gout
_____high blood pressure
_____polio
_____liver disease
_____bladder/kidney problems
_____stomach pain/ulcers
_____arthritis
_____heart attack/problems
_____VD Gonorrhea/Syphilis
_____thyroid disease
_____diverticulosis
_____blood transfusions
_____German Measles
_____TB
_____Scarlet/Rheumatic Fever
_____yellow jaundice

Others _____

PAST SURGERIES & HOSPITALIZATIONS _____

ALLERGIES _____

PAST ACCIDENTS _____

Present medications _____

Do you smoke? _____ Packs/Day _____ Do you drink alcohol? _____ How much a day? _____

WOMEN ONLY:
Date of last period _____ Last pap smear _____
Age of first period _____ Frequency of periods _____
Days duration _____ Number of pregnancies _____
Number of live births _____ Could you be pregnant now? _____

FAMILY HISTORY: Check if anyone in your family has any of the following:(include parents, grandparents, children,aunts, uncles)

_____sugar (diabetes)
_____high blood pressure
_____heart problems
_____cancer
_____epilepsy
_____blood diseases/anemia
_____TB
_____asthma/allergies
_____glaucoma
_____kidney disease
_____Twins/Triplets

Other _____

INVENTORY OF SYSTEMS: Check if you have frequent problems with any of the following:

GENERAL
_____nervousness
_____family problems
_____weakness
_____fever
_____weight change
_____always hungry or thirsty
_____sleeping problems
_____radiation treatments

HEAD AND NECK
_____headaches
_____sinus pain
_____neck lumps or swellings

EYES
_____glasses
_____double/blurry vision
_____halos around lights
_____pain or itching
_____discharge from eyes

EARS AND NOSE
_____earache
_____ringing in ears
_____hearing problems
_____nasal congestion
_____nose bleeds

MOUTH AND THROAT
_____dental problems gums bleed/swell
_____sore throat
_____hoarse voice
_____difficulty swallowing
_____enlarged tonsils

LUNGS
_____cough up blood
_____wheezing
_____coughing spells
_____cough up phlegm
_____problems breathing
_____shortness of breath

CARDIOVASCULAR
_____chest pain
_____racing/skipped beats
_____swelling of feet
_____cannot breathe lying down
_____leg cramps
_____heart murmur

SKIN
_____rashes/itching
_____moles/growths changing
_____bruise easily

DIGESTIVE
_____poor appetite
_____heartburn
_____stomach pain
_____gas/belching
_____nausea
_____vomiting
_____vomiting blood
_____diarrhea
_____constipation
_____bloody/black stools

URINARY
_____burning with urination
_____brown/black or bloody urine
_____problem starting stream
_____urgency/wetting

NEUROMUSCULAR
_____joint/muscle ache
_____joint swelling
_____paralysis
_____tremors
_____fainting/dizzy
_____numb limbs

MEN ONLY
_____pain in testicles
_____discharge
_____lump on testicles
_____prostate trouble
_____sexual problems

WOMEN ONLY
_____breast discharge
_____lump in breast
_____irregular periods
_____painful periods
_____heavy flow
_____vaginal discharge
_____hot flashes
_____sexual problems
_____using pilll/IUD

OTHERS: _____

_____

_____

Signature _____ Date _____