PATIENT NAME:	DATE / /

NAME (FIRST, MIDDLE, LAST)	AGE	DATE OF BIRTH
STREET ADDRESS		SEX ☐ MALE ☐ FEMALE
(CITY, STATE & ZIP)		HOME PHONE
OCCUPATION		WORK PHONE
EMERGENCY CONTACT		EMERGENCY CONTACT PHONE

MARITAL STATUS

☐ SINGLE ☐ MARRIED ☐ SEPARATED ☐ DIVORCED ☐ WIDOWED

IF MARRIED, SPOUSE'S NAME

CHILDREN'S NAME (S) AND AGE (S)		

ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES ☐ YES ☐ NO

(IF YES, PLEASE LIST THE NAME OF THE MEDICATION OR SUBSTANCE AND TYPE OF REACTION):

PAST MEDICAL HISTORY & REVIEW OF SYSTEMS

PLEASE CIRCLE IF YOU HAVE HAD PROBLEMS WITH OR ARE PRESENTLY COMPLAINING OF ANY OF THE FOLLOWING

☐ 1. HIGH BLOOD PRESSURE	☐ 19. PNEUMONIA	☐ 37. UNEXPLAINED WEIGHT GAIN / LOSS	☐ 54. SKIN DISEASES
☐ 2. DIABETES	☐ 20. PERSISTENT COUGH	☐ 38. HEMORRHOIDS	☐ 55. BLOOD DISORDERS
☐ 3. CANCER	☐ 21. T.B.	☐ 39. GALL BLADDER DISEASE	☐ 56. VENEREAL DISEASES
☐ 4. HEART DISEASE	☐ 22. HAY FEVER	☐ 40. COLITIS	☐ 57. ANXIETY
☐ 5. CHEST PAIN / CHEST TIGHTNESS	☐ 23. ABDOMINAL DISCOMFORT	☐ 41. HEPATITIS OR JAUNDICE	☐ 58. DEPRESSION
☐ 6. SHORTNESS OF BREATH	☐ 24. INDIGESTION	☐ 42. THYROID DISEASE	☐ 59. ANEMIA
☐ 7. SWOLLEN ANKLES	☐ 25. NAUSEA	☐ 43. HEAD OR NECK RADIATION	☐ 60. ALCOHOL ABUSE
☐ 8. PALPITATIONS	☐ 26. VOMITING	☐ 44. HEADACHE	☐ 61. DRUG ABUSE
☐ 9. LIGHTHEADEDNESS	☐ 27. CONSTIPATION	☐ 45. KIDNEY DISEASES	☐ 62. GOUT
☐ 10. FREQUENT URINATION	☐ 28. DIARRHEA	☐ 46. KIDNEY STONES	☐ 63. COUGHING BLOOD
☐ 11. RHEUMATIC FEVER	☐ 29. BLOOD IN STOOL	☐ 47. DIFFICULTY URINATING	☐ 64. CHANGE IN APPETITE
☐ 12. ASTHMA	☐ 30. ULCERS	☐ 48. PAINFUL BOWEL MOVEMENT	☐ 65. INSOMNIA
☐ 13. BREAST MASSES / DISCHARGE	☐ 31. URINATE AT NIGHT	☐ 49. BLOOD IN URINE	☐ 66. RINGING IN EARS
☐ 14. DEAFNESS	☐ 32. WEAKNESS	☐ 50. NASAL DISCHARGE	☐ 67. TINGLING/ NUMBNESS
☐ 15. MUSCLE PAIN	☐ 33. URINARY INCONTINENCE	☐ 51. DEFORMITIES	☐ 68. SORENESS OF THROAT
☐ 16. URINARY INFECTIONS	☐ 34. POST NASAL DRIP	☐ 52. ARTHRITIS	☐ 69. OTHER (PLEASE SPECIFY):
☐ 17. NECK STIFFNESS	☐ 35. DIFFICULTY SWALLOWING	☐ 53. LOW BACK PROBLEMS	
☐ 18. BRONCHITIS	☐ 36. CHANGE IN BOWEL HABITS		

PATIENT NAME:	DATE / /

GYNECOLOGIC AND OBSTETRIC HISTORY

AGE AT ONSET OF PERIODS:	FREQUENCY:	LENGTH OF PERIOD:
PREGNANCIES:	BIRTHS:	MISCARRIAGES:
PROLONGED OR ABNORMAL BLEEDING: ☐ NO ☐ YES (PLEASE DESCRIBE):		
LEAKAGE OF URINE: ☐ NO ☐ YES (PLEASE DESCRIBE):		
PELVIC PAIN: ☐ NO ☐ YES (PLEASE DESCRIBE):		
ABNORMAL DISCHARGE: ☐ NO ☐ YES (PLEASE DESCRIBE):		
HISTORY OF ABNORMAL PAP SMEAR: ☐ NO ☐ YES (TYPE OF TREATMENT):		

NEXT HISTORY DUE: _____

PLEASE LIST AND SUPPLY THE DATES OF:

OPERATIONS:

HOSPITALIZATIONS OTHER THAN FOR SURGERY:

IMMUNIZATION HISTORY – HAVE YOU HAD:	PNEUMOVAX IMMUNIZATION? ☐ NO ☐ YES WHEN?
HEPATITIS B? ☐ NO ☐ YES WHEN?	FLU IMMUNIZATION? ☐ NO ☐ YES WHEN?
OTHER? ☐ NO ☐ YES WHEN?	TETANUS IMMUNIZATION? ☐ NO ☐ YES WHEN?

WHEN WAS YOUR LAST:

PAP SMEAR?	BREAST EXAM?	STOOL CHECK FOR BLOOD?
HEPATITIS B?	CHOLESTEROL CHECK?	PROSTATE EXAM?

FAMILY HISTORY

HAS ANY MEMBER OF YOUR FAMILY (INCLUDING PARENTS, GRANDPARENTS, AND SIBLINGS) EVER HAD THE FOLLOWING?

ILLNESS	WHICH FAMILY MEMBERS?	APPROX. AGE WHEN DIAGNOSED
CANCER (DESCRIBE TYPE)		
HYPERTENSION (HIGH BLOOD PRESSURE)		
HEART DISEASE		
DIABETES		
STROKES		
MENTAL DISEASE (ANXIETY, DEPRESSION, ETC.)		
DRUG OR ALCOHOL ADDICTION		
GLAUCOMA		
BLEEDING DISEASES		
OTHER		

PATIENT NAME:	DATE / /

MEDICATIONS (PRESCRIPTION, OVER-THE-COUNTER, VITAMINS, HERBS, ETC.)			
DRUG NAME	DOSE	DRUG NAME	DOSE

PATIENT NAME:	DATE / /

PHYSICAL EXAMINATION
(To be completed by physician)

TO THE EXAMINER: Please review the patient's history and complete the Medical Examination form. Please comment on all positive findings and be sure all information is complete.

Name _____ Birthdate _____

Blood Pressure _____ Pulse _____ Weight _____ Height _____

Visual Acuity: OD 20/_____ OS 20/_____ Corrective lenses _____

ANY ABNORMALITIES OF:

	YES	NO	If yes, please explain
Skin			
Eyes, Head, Ears, Nose, Throat			
Neck, Thyroid			
Lungs			
Heart			
Abdomen			
Genitourinary			
Hernia			
Extremities/Joint			
Neurological			
Mental Status			

Laboratory: _____

Hgb/Hct: _____ Urine: _____ Sugar Protein: _____

Does the patient have any illnesses or health condition that may affect his/her activities? If yes, please describe: _____

_____

Does the patient have any illnesses or health condition that may affect the safety of patients in a health care setting? If yes, please describe:

_____

Is the patient on any medication? _____

_____

Is the patient under treatment for any medical or emotional conditions (including allergies)? _____

_____

Signature M.D./N.P. _____ Date _____

Print Name _____ Telephone _____

Address _____