

PATIENT NAME:	DATE / /
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NAME (FIRST, MIDDLE, LAST)	AGE	DATE OF BIRTH
STREET ADDRESS		SEX <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
(CITY, STATE & ZIP)		HOME PHONE
OCCUPATION		WORK PHONE
EMERGENCY CONTACT		EMERGENCY CONTACT PHONE
MARITAL STATUS <input type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED <input type="checkbox"/> SEPARATED <input type="checkbox"/> DIVORCED <input type="checkbox"/> WIDOWED		
IF MARRIED, SPOUSE'S NAME		
CHILDREN'S NAME (S) AND AGE (S)		
ALLERGIES TO MEDICATIONS, X-RAY DYES, OR OTHER SUBSTANCES <input type="checkbox"/> YES <input type="checkbox"/> 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			
<input type="checkbox"/> 1. HIGH BLOOD PRESSURE <input type="checkbox"/> 2. DIABETES <input type="checkbox"/> 3. CANCER <input type="checkbox"/> 4. HEART DISEASE <input type="checkbox"/> 5. CHEST PAIN / CHEST TIGHTNESS <input type="checkbox"/> 6. SHORTNESS OF BREATH <input type="checkbox"/> 7. SWOLLEN ANKLES <input type="checkbox"/> 8. PALPITATIONS <input type="checkbox"/> 9. LIGHTHEADEDNESS <input type="checkbox"/> 10. FREQUENT URINATION <input type="checkbox"/> 11. RHEUMATIC FEVER <input type="checkbox"/> 12. ASTHMA <input type="checkbox"/> 13. BREAST MASSES / DISCHARGE <input type="checkbox"/> 14. DEAFNESS <input type="checkbox"/> 15. MUSCLE PAIN <input type="checkbox"/> 16. URINARY INFECTIONS <input type="checkbox"/> 17. NECK STIFFNESS <input type="checkbox"/> 18. BRONCHITIS	<input type="checkbox"/> 19. PNEUMONIA <input type="checkbox"/> 20. PERSISTENT COUGH <input type="checkbox"/> 21. T.B. <input type="checkbox"/> 22. HAY FEVER <input type="checkbox"/> 23. ABDOMINAL DISCOMFORT <input type="checkbox"/> 24. INDIGESTION <input type="checkbox"/> 25. NAUSEA <input type="checkbox"/> 26. VOMITING <input type="checkbox"/> 27. CONSTIPATION <input type="checkbox"/> 28. DIARRHEA <input type="checkbox"/> 29. BLOOD IN STOOL <input type="checkbox"/> 30. ULCERS <input type="checkbox"/> 31. URINATE AT NIGHT <input type="checkbox"/> 32. WEAKNESS <input type="checkbox"/> 33. URINARY INCONTINENCE <input type="checkbox"/> 34. POST NASAL DRIP <input type="checkbox"/> 35. DIFFICULTY SWALLOWING <input type="checkbox"/> 36. CHANGE IN BOWEL HABITS	<input type="checkbox"/> 37. UNEXPLAINED WEIGHT GAIN / LOSS <input type="checkbox"/> 38. HEMORRHOIDS <input type="checkbox"/> 39. GALL BLADDER DISEASE <input type="checkbox"/> 40. COLITIS <input type="checkbox"/> 41. HEPATITIS OR JAUNDICE <input type="checkbox"/> 42. THYROID DISEASE <input type="checkbox"/> 43. HEAD OR NECK RADIATION <input type="checkbox"/> 44. HEADACHE <input type="checkbox"/> 45. KIDNEY DISEASES <input type="checkbox"/> 46. KIDNEY STONES <input type="checkbox"/> 47. DIFFICULTY URINATING <input type="checkbox"/> 48. PAINFUL BOWEL MOVEMENT <input type="checkbox"/> 49. BLOOD IN URINE <input type="checkbox"/> 50. NASAL DISCHARGE <input type="checkbox"/> 51. DEFORMITIES <input type="checkbox"/> 52. ARTHRITIS <input type="checkbox"/> 53. LOW BACK PROBLEMS	<input type="checkbox"/> 54. SKIN DISEASES <input type="checkbox"/> 55. BLOOD DISORDERS <input type="checkbox"/> 56. VENEREAL DISEASES <input type="checkbox"/> 57. ANXIETY <input type="checkbox"/> 58. DEPRESSION <input type="checkbox"/> 59. ANEMIA <input type="checkbox"/> 60. ALCOHOL ABUSE <input type="checkbox"/> 61. DRUG ABUSE <input type="checkbox"/> 62. GOUT <input type="checkbox"/> 63. COUGHING BLOOD <input type="checkbox"/> 64. CHANGE IN APPETITE <input type="checkbox"/> 65. INSOMNIA <input type="checkbox"/> 66. RINGING IN EARS <input type="checkbox"/> 67. TINGLING/ NUMBNESS <input type="checkbox"/> 68. SORENESS OF THROAT <input type="checkbox"/> 69. OTHER (PLEASE SPECIFY):

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GYNECOLOGIC AND OBSTETRIC HISTORY		
AGE AT ONSET OF PERIODS:	FREQUENCY:	LENGTH OF PERIOD:
PREGNANCIES:	BIRTHS:	MISCARRIAGES:
PROLONGED OR ABNORMAL BLEEDING:	<input type="checkbox"/> NO <input type="checkbox"/> YES (PLEASE DESCRIBE):	
LEAKAGE OF URINE:	<input type="checkbox"/> NO <input type="checkbox"/> YES (PLEASE DESCRIBE):	
PELVIC PAIN:	<input type="checkbox"/> NO <input type="checkbox"/> YES (PLEASE DESCRIBE):	
ABNORMAL DISCHARGE:	<input type="checkbox"/> NO <input type="checkbox"/> YES (PLEASE DESCRIBE):	
HISTORY OF ABNORMAL PAP SMEAR:	<input type="checkbox"/> NO <input type="checkbox"/> 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? <input type="checkbox"/> NO <input type="checkbox"/> YES WHEN?
HEPATITIS B? <input type="checkbox"/> NO <input type="checkbox"/> YES WHEN?		FLU IMMUNIZATION? <input type="checkbox"/> NO <input type="checkbox"/> YES WHEN?
OTHER? <input type="checkbox"/> NO <input type="checkbox"/> YES WHEN?		TETANUS IMMUNIZATION? <input type="checkbox"/> NO <input type="checkbox"/> 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		

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

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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 _____