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***The following information will become part of your confidential medical record***

**Date/Time of First Appointment _____/______/_____ at ______ m.**

**Name**: ____________________________________________ Birthdate: _____/______/____
LAST FIRST MIDDLE INITIAL

**HISTORY OF ILLNESS**
(Please describe the problems you are having):

**PAST MEDICAL HISTORY**
(Please list all medical problems, past surgeries, and hospitalizations including dates and hospital names):

**CURRENT MEDICATIONS:**

| Name of Medication | Dosage | Start Date | Prescribed by |
|---|---|---|---|
| | | | |

**ALLERGIES:**

| Name of Medication | Reaction |
|---|---|
| | |

## SOCIAL HISTORY

Sex : □ Male □ Female Education level:________________ Ethnicity:__________________

Marital Status: □ Single □ Married □ Widowed □ Divorced (□ Children if yes, how many _____ )

InterestHobbies:______________________________________________________________________

Alcohol use: □ Never □ Former when did you stop? □ Occasional □ Daily

Tobacco use: □ Never □ Former when did you stop? □ Current

Cigarettes:_______ Cigars:_______ Chewing Tobacco:_______

Illicit drugs: (explain)

## FAMILY HISTORY

Is there any family history of colon cancer? Circle One Y N
Is there any family history of liver disease? Circle One Y N

List below any cases of cancer, peptic ulcer, Crohn's disease, ulcerative colitis, gall bladder disease, liver, hereditary conditions, or other significant conditions: (e.g., heart disease, hypertension, diabetes, etc.)

| | If deceased, cause of death | Age |
|---|---|---|
| Parents________________________________ | ________________________________ | |
| Brothers/Sisters________________________ | ________________________________ | |
| Grandparents__________________________ | ________________________________ | |

## OCCUPATIONAL HISTORY

Current Employment____________________ Past Employment_________________________

## REVIEW OF SYSTEMS AND SYMPTOMS

Please √ the following symptom/disease you've recently had or now have.

**Constitutional**
□ Recent Weight Loss/Amount ____
□ Recent Weight Gain/Amount ____
□ Fever
□ Fatigue
□ Weakness
□ Change in appetite
□ Special Diet for Medical Condition
□ Other_______________

**Ears**
□ Hearing loss
□ Hearing aid
□ Ear pain
□ Ear ringing
□ Other_______________

**Throat**
□ Frequent sore throat
□ Difficulty swallowing
□ Hoarseness
□ Other______________

**Nose**
□ Frequent discharge
□ Nose bleeds
□ Other______________

**Mouth**
□ Ulcers/sores
□ Loss of taste
□ Full/partial dentures
□ Other______________

**Eyes**
□ Blurred or double vision
□ Loss of sight
□ Glasses
□ Pain
□ Other______________

**Allergic/Immunologic**
□ Allergies/not medication
□ Abnormal immune system
□ HIV / AIDS
□ Other_______________

**Lungs/Respiratory**
□ Shortness of breath
□ Asthma
□ Wheezing/Cough
□ Abnormal Chest x-ray
□ Night Sweats
□ Tuberculosis
□ Other_______________

**Genitourinary**
□ Urinary tract infection
□ Blood in urine
□ Burning with urination
□ Difficult urination
□ Kidney stones
□ Sexual difficulties
□ Prostate trouble
□ Other_______________

**Psychiatric**
□ Depression
□ Past evaluation/treatment
□ Other_______________

**Musculoskeletal**
☐ Arthritis
☐ Joint swelling
☐ Lupus, scleroderma or related
☐ Joint pain
☐ Back pain
☐ Muscle weakness/pain
☐ Other ____________

**Skin**
☐ Dermatitis/rash/hives
☐ Jaundice/yellow skin
☐ History of Mammogram
☐ Breast cancer
☐ Itching
☐ Psoriasis
☐ Nodules/bumps
☐ Bruise easily
☐ Other_______________

**Hematologic/Lymphatic**
☐ Swollen glands
☐ Blood disease
☐ Anemia
☐ Abnormal blood count
☐ Bruise easily
☐ Blood transfusion when?______
☐ Other_______________

**Abdominal/Gastrointestinal**
☐ Diarrhea
☐ Vomiting blood
☐ Vomiting
☐ Constipation
☐ Crohn's disease
☐ Ulcerative colitis
☐ Inguinal hernia
☐ Esophageal reflux
☐ Irritable bowel syndrome
☐ Ulcers
☐ Abdominal Pain
☐ Indigestion
☐ Nausea
☐ Bloating
☐ Difficulty swallowing food
☐ Gallstones
☐ Rectal Bleeding
☐ Hepatitis/liver disease
☐ Hemorrhoids
☐ Belching – gas
☐ Colitis
☐ Inflammatory bowel disease
☐ Heartburn
☐ Fecal incontinence/stool leakage
☐ Other ____________

**Endocrine**
☐ Diabetes
☐ Thyroid disease
☐ Post-menopausal
☐ Other_______________

**Cardiovascular**
☐ Chest pain
☐ Mitral valve prolapse
☐ Ankle/leg swelling
☐ Pacemaker
☐ History of heart attack
☐ Irregular heart beat
☐ Palpitations
☐ High blood pressure
☐ Other _______________

**Neurological**
☐ Memory loss/Confusion
☐ Seizure disorder
☐ Tremors
☐ Dizziness
☐ Headaches
☐ Fainting
☐ Other________________

Date of last eye exam?___________

**Menstrual:**
Age when periods began:_______ regular? _______
Date of last period_____________________________
Date of last pap smear__________________________
Bleeding after menopause?______________________

**Are outside medical records available?**
Circle one Y N

Patient's Signature:__________________________________________________ Date: _________

Physician Signature: _________________________________________________ Date: _________