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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 |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
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| | | | |
| | | | |
| | | | |
| | | | |

**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
- 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: _________