

Patient Name: _____

Date: _____

Please mark in the box next to all symptoms you currently have or have had in the past.

GENERAL

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Poor appetite
<input type="checkbox"/>	<input type="checkbox"/>	Excessive appetite
<input type="checkbox"/>	<input type="checkbox"/>	Insomnia
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue
<input type="checkbox"/>	<input type="checkbox"/>	Fevers
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats
<input type="checkbox"/>	<input type="checkbox"/>	Sweat easily
<input type="checkbox"/>	<input type="checkbox"/>	Chills
<input type="checkbox"/>	<input type="checkbox"/>	Localized weakness
<input type="checkbox"/>	<input type="checkbox"/>	Poor coordination
<input type="checkbox"/>	<input type="checkbox"/>	Change in appetite
<input type="checkbox"/>	<input type="checkbox"/>	Strong thirst
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

CARDIOVASCULAR

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Low blood pressure
<input type="checkbox"/>	<input type="checkbox"/>	Blood clots
<input type="checkbox"/>	<input type="checkbox"/>	Palpitations
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Phlebitis
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/Angina
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heart beat
<input type="checkbox"/>	<input type="checkbox"/>	Cold hands/feet
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of hands/feet
<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

FEMALE

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urinary tract infections
<input type="checkbox"/>	<input type="checkbox"/>	Frequent vaginal infections
<input type="checkbox"/>	<input type="checkbox"/>	Pain/itching of genitalia
<input type="checkbox"/>	<input type="checkbox"/>	Genital lesions/discharge
<input type="checkbox"/>	<input type="checkbox"/>	Pelvic inflammatory disease
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal pap smear
<input type="checkbox"/>	<input type="checkbox"/>	Irregular periods
<input type="checkbox"/>	<input type="checkbox"/>	Painful menstrual periods
<input type="checkbox"/>	<input type="checkbox"/>	Premenstrual syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Abnormal bleeding
<input type="checkbox"/>	<input type="checkbox"/>	Menopausal syndrome
<input type="checkbox"/>	<input type="checkbox"/>	Breast lumps
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

SKIN AND HAIR

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Rashes
<input type="checkbox"/>	<input type="checkbox"/>	Hives
<input type="checkbox"/>	<input type="checkbox"/>	Itching
<input type="checkbox"/>	<input type="checkbox"/>	Eczema
<input type="checkbox"/>	<input type="checkbox"/>	Pimples
<input type="checkbox"/>	<input type="checkbox"/>	Dryness
<input type="checkbox"/>	<input type="checkbox"/>	Tumors/lumps
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

RESPIRATORY

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Asthma
<input type="checkbox"/>	<input type="checkbox"/>	Bronchitis
<input type="checkbox"/>	<input type="checkbox"/>	Frequent colds
<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Cough
<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood
<input type="checkbox"/>	<input type="checkbox"/>	Production of phlegm
<input type="checkbox"/>	<input type="checkbox"/>	Emphysema
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath
<input type="checkbox"/>	<input type="checkbox"/>	Chronic obstructive pulmonary disease
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

NEUROLOGICAL

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Tremors
<input type="checkbox"/>	<input type="checkbox"/>	Numbness or tingling of limbs
<input type="checkbox"/>	<input type="checkbox"/>	Concussion
<input type="checkbox"/>	<input type="checkbox"/>	Pain
<input type="checkbox"/>	<input type="checkbox"/>	Paralysis
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

HEAD AND NECK

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Neck stiffness
<input type="checkbox"/>	<input type="checkbox"/>	Enlarged lymph glands
<input type="checkbox"/>	<input type="checkbox"/>	Headaches
<input type="checkbox"/>	<input type="checkbox"/>	Concussions
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

GASTRO-INTESTINAL

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Nausea
<input type="checkbox"/>	<input type="checkbox"/>	Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Belching
<input type="checkbox"/>	<input type="checkbox"/>	Blood in stools/black stools
<input type="checkbox"/>	<input type="checkbox"/>	Bad breath
<input type="checkbox"/>	<input type="checkbox"/>	Rectal pain
<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Pain or cramps
<input type="checkbox"/>	<input type="checkbox"/>	Indigestion
<input type="checkbox"/>	<input type="checkbox"/>	Gall bladder disorder
<input type="checkbox"/>	<input type="checkbox"/>	Gas
<input type="checkbox"/>	<input type="checkbox"/>	IBS
<input type="checkbox"/>	<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

PSYCHOLOGICAL

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety/Stress
<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Emotional/Psychological issues
<input type="checkbox"/>	<input type="checkbox"/>	Mania/bipolar
<input type="checkbox"/>	<input type="checkbox"/>	PTSD
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

EARS

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Infection
<input type="checkbox"/>	<input type="checkbox"/>	Ringing
<input type="checkbox"/>	<input type="checkbox"/>	Decreased hearing
<input type="checkbox"/>	<input type="checkbox"/>	Discharge
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

MALE

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Pain/itching of genitalia
<input type="checkbox"/>	<input type="checkbox"/>	Genital lesions/discharge
<input type="checkbox"/>	<input type="checkbox"/>	Impotence
<input type="checkbox"/>	<input type="checkbox"/>	Weak urinary stream
<input type="checkbox"/>	<input type="checkbox"/>	Lumps in testicles
<input type="checkbox"/>	<input type="checkbox"/>	Prostatitis
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

EYES

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision
<input type="checkbox"/>	<input type="checkbox"/>	Visual changes
<input type="checkbox"/>	<input type="checkbox"/>	Poor night vision
<input type="checkbox"/>	<input type="checkbox"/>	Spots
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts
<input type="checkbox"/>	<input type="checkbox"/>	Glasses/Contacts
<input type="checkbox"/>	<input type="checkbox"/>	Eye inflammation
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

GENITO-URINARY

Past	Current	
<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones
<input type="checkbox"/>	<input type="checkbox"/>	Pain on urination
<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	Urgency to urinate
<input type="checkbox"/>	<input type="checkbox"/>	Unable to hold urine
<input type="checkbox"/>	<input type="checkbox"/>	Other _____

NOSE, THROAT, AND MOUTH

Past	Present	
<input type="checkbox"/>	<input type="checkbox"/>	Nose bleeds
<input type="checkbox"/>	<input type="checkbox"/>	Sinus infection
<input type="checkbox"/>	<input type="checkbox"/>	Hay fever or allergies
<input type="checkbox"/>	<input type="checkbox"/>	Recurring sore throats
<input type="checkbox"/>	<input type="checkbox"/>	Grinding teeth
<input type="checkbox"/>	<input type="checkbox"/>	Difficulty swallowing

Patient History (continued)

Patient Name: _____ **Date:** _____

Family History: Complete for each family member, placing an X in the appropriate box.

	Self	Mother	Father	Brother	Sister	Grandparents	Child
Allergies							
Blood Disorder/ Anemia							
Diabetes							
Cancer or Tumors							
Seizures							
Kidney/ Bladder Disorder							
Stomach/Intestinal Disorder							
Drug/ Alcohol Abuse							
Tuberculosis							
Heart Disease							
Stroke							
Depression/ Mental Illness							
Anxiety							
Arthritis							
Asthma							
Back Problems							
Bursitis							
Constipation							
Headaches							
Hepatitis							
High Blood Pressure							
HIV/AIDS							
Immune Disorder							
Insomnia							
Kidney Problems							
Liver Problems							
Migraines							
Neck Pain							
Thyroid Disorder							
Weight Problems							
Emotional Problems							
Other							
Age at Death							

Major Hospitalizations: List the most recent hospitalizations for any serious medical illness or operation.

Year	Operation or Illness	Hospital Name	City, State

Medications / Supplements: List all medications, supplements, vitamins and herbs you use, including those used only on occasion.

Name	Purpose	How long	Dose

Drug Allergies:

Habits: Check any of the habits listed below that apply to you now or in the past.

Coffee	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cups per day/ week	Age started	Age quit
Tobacco	Yes <input type="checkbox"/> No <input type="checkbox"/>	Cigarettes per day	Age started	Age quit
Marijuana	Yes <input type="checkbox"/> No <input type="checkbox"/>	Use per day/week	Age started	Age quit
Alcohol	Yes <input type="checkbox"/> No <input type="checkbox"/>	Use per day/week	Age started	Age quit
Crack/Cocaine	Yes <input type="checkbox"/> No <input type="checkbox"/>	Use per day/week	Age started	Age quit
Heroin	Yes <input type="checkbox"/> No <input type="checkbox"/>	Use per day/week	Age started	Age quit
Other	Yes <input type="checkbox"/> No <input type="checkbox"/>	Use per day/week	Age started	Age quit