

PATIENT INFORMATION

Name: _____ Date of Birth: _____ Today's Date: _____

In the past year or since your last annual exam, have you had any of the following:

Please list any NEW medical diagnoses/procedures for yourself:

Please list any NEW medications:

Any CHANGES to your life or living situation (new significant other, new job, new family member, move):

Any problems with your current medications Yes No If yes, please explain:

SOCIAL HISTORY

Marital Status Single Married Divorced Widowed Other: _____

Occupation: _____

Children Yes No Number of living children? _____

Are you sexually active? Yes No With Men? Yes No With Women? Yes No

Do you exercise regularly? Yes No How often per week? _____ What type of exercise? _____

Tobacco

Are you a current smoker? Yes No How many per day? _____ How many years? _____

Do you use any other type of tobacco? Yes No If yes, what? _____

Alcohol

Do you drink alcohol? Yes No Drinks per week on average? _____ Drinks per month on average? _____

Drug Use

Do you use drugs currently? Yes No or have you in the past? Yes No What? _____

Are you experiencing any of the following symptoms? Please circle:

GENERAL

Fever
Chills
Fatigue
Weight change

CARDIOVASCULAR

Chest pain
Leg swelling
Irregular/fast heartbeat
Difficulty breathing

URINARY

Pain/blood
Frequency
Incontinence
Hesitancy

MUSCLES

Joint swelling
Weakness
Pain
Stiffness

PSYCHIATRY

Depression
Anxiety
Memory problems

EYES

Vision change
Redness/irritation
Discharge
Pain

RESPIRATORY

Shortness of breath
Cough
Wheezing
Sputum or blood

GYNECOLOGICAL

Discharge
Irregular bleeding
Low libido
Pelvic pain

SKIN

Rash
Lesion
Mole changes
Open sores

ENDOCRINE

Heat/cold intolerance
Excessive thirst
Excessive urination

ENT

Sore throat
Ear pain
Congestion/pressure
Nose bleeds

GASTROINTESTINAL

Abdominal pain
Nausea/vomiting
Constipation/diarrhea
Blood in stools

MALE

Discharge
Erectile dysfunction
Weak stream
Testicular lump/pain
Low libido

NEUROLOGICAL

Headaches
Dizziness/fainting
Numbness/tingling
Tremor

HEMATOLOGIC

Easy bleeding
Easy bruising
Past transfusion

ALLERGIC

Hives
Tongue swelling
Allergic reaction