

Patient Name _____ Date _____

Date of Birth _____ Age _____ Chart Number _____

Current Problem

Why are you here today? Describe your chief complaint / symptoms.

Who referred you to our office? _____

General Information

How would you describe your health? Good Fair Poor

What is your occupation and nature of work? _____

Do you have any contact with hazardous materials such as asbestos or chemical? _____

What are your hobbies? _____

What is the highest level of education attained? No high school diploma High school diploma Some college College Graduate Masters or higher

What is your religious preference? _____

What is your marital status? Single Divorced Married Widowed

Do you have any children? Yes No If yes, how many and what are their ages?

How many people live at your house?_____ What is their relation to you?_____

Health Habits

Do you now or have you ever smoked cigarettes, cigars or a pipe? Yes No

If yes, how many per day?_____ How many years did you smoke?_____

If you have quit, how long has it been since you smoked?_____

Do you drink alcoholic beverages? Yes No How much per week?_____

Do you currently or have you ever used street drugs? Yes No If yes, what did you use and for how long?_____

Do you exercise regularly? Yes No How often?_____

History

What childhood illnesses did you have?_____

As an adult, check and date any illnesses you have experienced.

Illness	√	Date	Illness	√	Date
Arthritis/Rheumatism			Diabetes		
Birth Defects			Glaucoma		
Heart Disease			Hepatitis		
High Blood Pressure			Liver Disease		
Kidney Disease			Jaundice		
Cancer			Thyroid Disease		
Anemia / Blood Disorders			Tuberculosis		
Alcoholism			Other:		

Explanation_____

Have you ever had a blood transfusion? Yes No If yes, when_____

Have you ever been hospitalized for anything other than childbirth? Yes No If yes, what was the reason and when did it occur?_____

Do you regularly have annual physicals? Yes No When was you last physical?_____ Which doctor did you see?_____

Check any of the following illnesses in which a family member has experienced.

Illness	√	Family Member/s
Anemia / Low Blood Disorders		
Cancer (if yes, what type/s)		
Arthritis		
Diabetes Mellitus		
Epilepsy		
Alcoholism		
Heart Disease		
High Blood Pressure		
Glaucoma		
Liver Disease		
Migraines		
Strokes		
Other:		
Other:		

Do you have any drug allergies? Yes No If yes, what medication are you allergic, what was your reaction, and when did this reaction occur?

Drug	Reaction	Date

What medication/s, vitamins, supplements or herbal medications have you taken over the last 3 months?_____

Review of Systems

Constitutional Symptoms

What is your current weight?_____ What has been your maximum weight?_____

When were you at your maximum weight?_____ What was your weight one year ago?_____ Have you had recent weight loss or weight gain?_____

Have you had fever, chills, or night sweats? Yes No If yes, how often?_____

Skin

Have you had any changes in color or texture of skin? Yes No

Does severe itching bother you? Yes No

Does your skin often break out in a rash? Yes No

Do you bruise easily or notice excessive bruising? Yes No

Hematological

Do you bruise easily? Yes No

Are you a free bleeder? Yes No

Have you ever had a bone marrow test? Yes No

Have you donated blood? Yes No

If yes, when was the last date donated?_____

HEENT

Are you hard of hearing? Yes No

Do you have frequent episodes of dizziness or light headedness? Yes No

Do you have constant noises in your ears? Yes No

Do you have hay fever? Yes No

Do you have false teeth? Yes No

Do you have bleeding gums? Yes No

Do you have pyorrhea or chronic gum problems? Yes No

Does your tongue get sore or burn? Yes No

Do you get frequent sore throats? Yes No

Do you frequently get hoarse? Yes No

Cardiovascular / Respiratory

Have you ever suffered from asthma? Yes No

Does chronic coughing trouble you? Yes No

Do you bring up phlegm? Yes No

If yes, what color?_____Amount?_____

Have you ever coughed up blood? Yes No

Do you have pains or discomfort in the heart or chest? Yes No

- Do you get tightness, pressure, squeezing, or burning in the chest during exertion or after meals? Yes No
- Are you often bothered by thumping of the heart or palpitations? Yes No
- Do you often have difficulty in breathing? Yes No
- Do you sometimes get out of breath just sitting still? Yes No
- Do you ever have to sit up at night to breathe? Yes No
- Do you use more pillows than you used to? Yes No
- If yes, how many? _____
- Do you have a heart murmur? Yes No
- Do you have varicose veins? Yes No

GI

- Do you usually belch a lot after eating? Yes No
- Are you often sick at your stomach? Yes No
- Do you suffer from indigestion? Yes No
- Do you have severe pains in your stomach? Yes No
- Has a doctor ever said you had stomach ulcers? Yes No
- Have you ever had blood in your stools? Yes No
- Do you suffer from frequent loose bowel movements? Yes No
- Do you suffer from constipation? Yes No
- Do you frequently use laxatives for constipation? Yes No
- Have you had a recent change in bowel habits? Yes No

GU

- How many times do you have to get up at night to urinate? _____
- Do you have to urinate frequently during the day? Yes No
- Do you ever have pain, burning, or stinging when you urinate? Yes No
- Do you sometimes lose control of your bladder? Yes No
- Have you noticed blood in your urine? Yes No

For Males Only

- Do you have any trouble with your nature (i.e. sexual relations)? Yes No
- Do you have trouble starting your stream when urinating? Yes No
- Do you have a weak urinary stream? Yes No

For Females Only

- At what age did you start menstruating (i.e. period)? _____
- When was your last normal period? _____ What is the length of flow? _____
- Do you have bleeding between periods? Yes No How many times have you been pregnant? _____ Have you had any miscarriages? Yes No If yes, how many? _____
- Have you had any abortions? Yes No If yes, how many? _____

For Females Only

Do you have hot flashes? Yes No
Have you gone through menopause? Yes No
If yes, how old were you? _____
Are you taking any hormones? Yes No
If yes, what? _____
When was the date of your last mammogram? _____
When was the date of your last Pap smear? _____

Musculoskeletal

Are your joints ever painfully swollen? Yes No
Do you have any muscle weakness? Yes No
Do you have any muscle tenderness? Yes No

Neurological

Do you suffer from frequent severe headaches? Yes No
Do you have constant numbness or tingling in any part
of your body? Yes No
Did you ever have a fit or convulsion (epilepsy)? Yes No
Do you often get spells of complete exhaustion or fatigue? Yes No
Do you have loss of memory? Yes No

Psychosocial

Do you have trouble sleeping? Yes No
Do you have anxiety or depression? Yes No

History Reviewed

ALL OTHER SYSTEMS REVIEWED AND NEGATIVE _____

Physician's Initials

I have reviewed and verified all information recorded with the patient.

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____

Physician's Signature: _____ Date: _____