NAME:	**AGE:**	**DATE:**

Married		**FEMALES:** Date of Last Menstrual Period	
Single		Date of Last Pap Smear	
Divorced		Date of Last Mammogram	
Widower			
Birth Date		**MALES:**	
Occupation		Date of Last Rectal Exam	
Last Physical Exam		Date of last PSA (Prostate Test)	
Allergies:			

FAMILY HISTORY				**Has any Blood Relative Ever Had:**		
	Age	**Health**	**Age at Death**	Cancer	**YES**	**NO**
Father				Tuberculosis		
Mother				Diabetes		
Brothers				Heart Trouble		
Sisters				High Blood Pressure		
Husband				Stroke		
Wife				Epilepsy		
Sons				Alzheimer's/ Dementia		
Daughters				Suicide		

Have you ever had an X-ray of:	**YES**	**NO**		**YES**	**NO**
Chest			**EKG: Electrocardiogram**		
Stomach					
Gallbladder			**IMMUNIZATIONS:**		
Extremities			Tetanus Shot		
Back			Pneumonia Shot		

ARE YOU NOW OR HAVE YOU WITHIN THE PAST YEAR TAKEN ANY:			
	YES	**NO**	
Insulin or RX for Diabetes			
Cortisone			
Nerve Pills			
Hormones			
Herbal Supplements			
Laxatives			
Vitamins			
Sleeping Pills			
Aspirin			

PERSONAL HISTORY					
Have you ever had:	**YES**	**NO**	Have you ever had:	**YES**	**NO**
Measles			Bone or Joint Disease		
German Measles			Polio or Meningitis		
Mumps			Kidney Disease		
Chicken Pox			Venereal Disease		
Whooping cough			Gallbladder Disease		
Scarlet Fever			Anemia, Jaundice		
Influenza			Food or Drug Poisoning		
Pneumonia			Chemical Poisoning		
Rheumatic Fever			Epilepsy		
Heart Disease			Migraine Headaches		
Arthritis/Rheumatism			Tuberculosis		
Diabetes			Cancer		
Colitis/Bowel Disease			Hemorrhoids/Rectal Disease		
Nervous Breakdown			Hay fever or Asthma		
Hives or Eczema			Frequent Infections or Boils		
AIDS			Hepatitis		
Any other diseases?					
Alcohol Use			If yes, how much Alcohol?		
Do you Smoke?			If yes, how many per day?		
Smoking Cessation Counseling Done?					
Have you ever had Blood or Plasma Transfusion?					
Have you ever had a Tonsillectomy?					
Have you ever had an Appendectomy?					
List any other Operations that you have had performed.				**YEAR**	
Have you been advised to have any surgical operation that Has not been done?				**YES**	**NO**
Have you been hospitalized for any illness? Please list details.					
Do you now have or have you had within the past year?					
Frequent, severe headache			Recurrent nose bleeds		
Fainting Spells			Recurrent head colds		
Dizziness on position			Sinus Trouble		
Seizures			Hay Fever		
Blurred or Double Vision			Persistent hoarseness		
Spots before eyes			Difficulty swallowing		
Any change in vision?			Enlarged Glands		
Do you wear glasses?			Last eye exam?		
Recurrent Earaches			Recurrent sore throats		
Discharge from ears			Recurrent sores in mouth		
Chest pain			Soreness or bleeding of gums		

CONTINUED FROM LAST PAGE					
	YES	NO		YES	NO
Coughing up blood			Pain in arms		
Night Sweats			Chronic or frequent cough		
Wake up at night short of breath			Short of Breath		
Palpations			Fluttering of Heart		
High Blood Pressure			Low Blood Pressure		
Swelling of hands			Swelling of feet or ankles		
Leg Cramps when walking or at night when trying to sleep					
Enlarged Veins in Legs			Recurrent Stomach Pain		
Belching or heartburn relieved by food or medication					
Persistent nausea			Persistent vomiting		
Vomiting blood			Abdominal Cramping		
Change in size, texture, or shape of Bowel Movements					
Pain or difficulty in starting urination					
Do you get up at night to urinate					
Do you have any blood in your urine					
Full feeling of bladder, but only small amount of urination					
Do you lose urine when you are coughing or sneezing					
Discharge from penis			Joint pains		
Backaches			Swelling of any joints		
Redness or heat of any joint			Muscle Spasms		
Growth in neck or throat			Hot Flashes		
Tiredness without reason			Brittleness of Nails		
Dryness of skin			Easy Bruising		
Inability to stand heat			Inability to stand cold		
Change in hair texture			Change in skin texture		
Any type of skin rash			Trembling of any extremity		
Tingling in hands or feet			Weakness in hands or feet		
Loss or Change in Sensation of Hands or Feet					
Please List Current Medications:					

______________________________________ **Date**: ______________

Patient Signature

______________________________________ **Date:** ______________

Physicians Signature