

NAME \_\_\_\_\_ DATE OF EXAM \_\_\_\_\_

AGE \_\_\_\_\_ BIRTHDATE \_\_\_\_\_ PHONE(home) \_\_\_\_\_ (work) \_\_\_\_\_

### Present Illness

List current problems

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_

### Past History

Please list

Drug Allergies \_\_\_\_\_

| Operations | type  | year  |
|------------|-------|-------|
| _____      | _____ | _____ |
| _____      | _____ | _____ |
| _____      | _____ | _____ |

Injuries, accidents, fractures, or concussions

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

| Immunizations         | initial series | last booster year |
|-----------------------|----------------|-------------------|
| Polio                 | _____          | _____             |
| Diphtheria/tetanus    | _____          | _____             |
| Measles/Mumps/Rubella | _____          | _____             |
| Smallpox              | _____          | _____             |
| Other                 | _____          | _____             |

| Tests       | what? | latest year |
|-------------|-------|-------------|
| Tuberculin  | _____ | _____       |
| X-rays      | _____ | _____       |
| Blood tests | _____ | _____       |
| Other       | _____ | _____       |

### Medicines currently taking

| name  | dosage | frequency |
|-------|--------|-----------|
| _____ | _____  | _____     |
| _____ | _____  | _____     |
| _____ | _____  | _____     |

### Illnesses - list significant past illnesses

| year  | illness |
|-------|---------|
| _____ | _____   |
| _____ | _____   |
| _____ | _____   |
| _____ | _____   |
| _____ | _____   |

### (Females Only)

#### Periods

Last period date \_\_\_\_\_

Days between \_\_\_\_\_

Regular? \_\_\_\_\_

Age at onset \_\_\_\_\_

Birth control type \_\_\_\_\_

DES exposure? \_\_\_\_\_

#### Pregnancies

Total # \_\_\_\_\_

Live births \_\_\_\_\_

Miscarriages \_\_\_\_\_

Abortions \_\_\_\_\_

Complications \_\_\_\_\_

### Family History

| age              | health summary |
|------------------|----------------|
| Father _____     | _____          |
| Mother _____     | _____          |
| Siblings _____   | _____          |
| Spouse _____     | _____          |
| Children 1 _____ | _____          |
| (name, 2 _____   | _____          |
| age & 3 _____    | _____          |
| sex) 4 _____     | _____          |


Circle those diseases any blood relative has had, and state who, including aunts, uncles, grandparents, etc.

|                 |                           |
|-----------------|---------------------------|
| Allergies _____ | Heart disease _____       |
| Asthma _____    | High blood pressure _____ |
| Arthritis _____ | Stroke _____              |
| Cancer _____    | Tuberculosis _____        |
| Diabetes _____  | Mental disease _____      |
| Bleeding _____  | Kidney _____              |
| Lung _____      | Epilepsy _____            |
| Other _____     |                           |

### Social History

|                  |                            |                            |
|------------------|----------------------------|----------------------------|
| Occupation _____ | Marital status _____       | Coffee/tea (cup/day) _____ |
| Education _____  | Sleep (hours) _____        | Smoking (pack/day) _____   |
| Recreation _____ | Alcohol (drink/week) _____ | Drug usage _____           |

**SHADED AREA FOR USE BY PHYSICIAN ONLY**

| Please circle any of these you have or have had and felt were significant. ↓ |  | ROS  | EXAMINATION   |
|--|--|--|---|
| <b>SKIN</b>  | Warts<br>Rash  | Troublesome lumps or moles   |   |
| <b>HEENT</b>   | Headaches<br>Dizziness<br>Fainting   | Visual/hearing problems<br>Problems with ears, nose, mouth, throat, sinuses, teeth, neck   |   |
| <b>RESP/CV</b>   | Chest pain<br>Cough<br>Heart murmur<br>Blood clots                                       | Shortness of breath<br>Swollen ankles<br>Varicose veins<br>Other heart/lung problems<br>Breast lumps or discharge                      | Breasts   |
| <b>GI</b>  | Nausea<br>Vomiting<br>Diarrhea<br>Constipation<br>Hemorrhoids<br>Jaundice<br>Weight Loss | Stomach pain<br>Rectal bleeding<br>Black-tarry BM's<br>Changed bowel habits<br>Changed size, shape or texture of BM's<br>Lost appetite | Rectal  |
| <b>GU</b>  | Pus or blood in urine<br>Kidney stone<br>Irreg periods<br>Lost bladder control           | Difficult, painful, or increased urination<br>Vaginal discharge, itching or burning<br>Sexual difficulties                             | Pelvic  |
| <b>MS/NEURO/P-S</b>  | Muscle cramps<br>Convulsions<br>Paralysis<br>Mental illness<br>Worries or tensions       | Back or joint pain or swelling<br>Weakness, numbness or tingling<br>Trouble sleeping   |  |
| <b>ENDO</b>  | Hot flashes<br>Fatigue<br>Dry skin<br>Brittle nails<br>Swollen glands                    | Intolerance of heat or cold<br>Change in hair or skin texture<br>Obesity   |   |

|        |               |
|--------|---------------|
| Height |               |
| Weight | (usual)       |
|        | (present)     |
|        | (Δ 6 Mo)      |
| BP     | (R)           |
|        | (L)           |
| Temp   |               |
| Vision | $\bar{c}$ (R) |
|        | (L)           |
|        | $\bar{s}$ (R) |
|        | (L)           |
| Hct    |               |
| U/A    |               |

| PROBLEMS              | PLAN |
|-----------------------|------|
| 1) Health maintenance | 1)   |