

Instructions:

Place an "X" in boxes that apply to you.

Make no marks in boxes that do not apply to you.

Complete all sections

Past Medical History: Medical problems pertaining only to you:**Cardiac / Heart**

I have no history of heart or blood pressure problems.

High Blood Pressure

Mitral Valve Prolapse

Heart Attack

Elevated Cholesterol

Angina

Elevated /abnormal Lipids

Atrial Fibrillation

Heart murmur

Irregular heart beat

Congestive heart failure

Other

Respiratory / Lungs / Breathing

I have no history of breathing or respiratory problems.

Black Lung

Pulmonary Embolism

Obstructive disease COPD

Sleep Apnea

Asthma

Lung Cancer

Pneumonia

Emphysema

Bronchitis

Other

Endocrine / Glands

I have no history of endocrine / glandular problems

Diabetes / Borderline or diet

Thyroid:

Diabetes / Pills

Thyroid Cancer

Diabetes requiring insulin

Thyroid surgery

Diabetes, Juvenile

Other

Circulation / Vascular

I have no history of vascular / circulation problems

Bad Circulation

Aneurysm

Carotid artery blockage

Aneurysm surgery

Stroke / Mini stroke

Arterial bypass (legs) surgery

Blood clots

Carotid surgery

Varicose Veins

Vena Cava filter

Other

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Arthritis / Musculoskeletal

- I have no history of arthritis or musculoskeletal problems
- | | |
|---|---|
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Scoliosis |
| <input type="checkbox"/> Osteoarthritis | <input type="checkbox"/> Neck surgery |
| <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Back surgery |
| <input type="checkbox"/> Lupus | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Shoulder tendonitis |
| <input type="checkbox"/> Gout | <input type="checkbox"/> Hip bursitis |
| <input type="checkbox"/> Psuedogout | <input type="checkbox"/> Fractures (please list) |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Walk with cane / crutch / walker |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Shoulder pain, tendonitis |

Neurological

- I have no history of neurological problems
- | | |
|--|--|
| <input type="checkbox"/> Dementia / Alzheimers | <input type="checkbox"/> Migraines |
| <input type="checkbox"/> Tremor | <input type="checkbox"/> Headache (not migraine) |
| <input type="checkbox"/> Neuropathy | <input type="checkbox"/> Parkinson's disease |
| <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Carpal tunnel |
| <input type="checkbox"/> Inherited neurological problems | <input type="checkbox"/> Stroke / Mini Strokes |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Seizures / Epilepsy |
| <input type="checkbox"/> Problems with balance | <input type="checkbox"/> Other |

Gastrointestinal / digestive

- I have no history of gastrointestinal / digestive problems
- | | |
|--|--|
| <input type="checkbox"/> Reflux / GERD | <input type="checkbox"/> Rectal or GI Bleeding |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Cirrhosis |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Colon Cancer |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Pancreatitis |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Other |

Genitourinary, Male (Men Only)

- I have no history of genitourinary problems.
- | | |
|---|---|
| <input type="checkbox"/> Prostate enlargement | <input type="checkbox"/> Prostate Cancer |
| <input type="checkbox"/> Testicle swelling | <input type="checkbox"/> Erectile dysfunction |
| <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Incontinence |
| <input type="checkbox"/> Testicular cancer | <input type="checkbox"/> Bladder tumor |
| <input type="checkbox"/> Abnormal PSA | <input type="checkbox"/> Genital infections / lesions |
| <input type="checkbox"/> Other | |

Genitourinary, Female (Women Only)

- I have no history of genitourinary problems.
- | | |
|--|---|
| <input type="checkbox"/> Urinary incontinence | <input type="checkbox"/> Breast cancer |
| <input type="checkbox"/> Frequent urinary infections | <input type="checkbox"/> Abnormal pap smear |
| <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Cervical dysplasia |
| <input type="checkbox"/> Ovarian cancer | <input type="checkbox"/> Cervical cancer |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Other |

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Female Menstrual / Birth History

- Age at start of menses _____
- Age at menopause _____
- Number of pregnancies _____
- Number of Births _____
- Number of C-sections _____

Renal / Kidneys

- I have no history of problems with my kidneys
- Kidney Stones Renal Cancer
- Kidney failure Dialysis
- Other

Blood

- I have no problems with blood or blood disorders and have not received a transfusion.
- Anemia Bleeding disorder
- Lymphoma B12 deficiency
- Multiple Myeloma Iron deficiency
- Other blood cancer Transfusion
- Blood clots (DVT) HIV, AIDS
- Immunosuppression Hepatitis C
- Lymph node enlargement Other

Hearing, Vision, Taste, Smell:

- I have no problems, with vision, taste, smell and do not wear glasses
- Hard of hearing Glasses / contacts
- Hearing aid Cataracts
- Ear surgery Glaucoma
- Neck surgery Macular degeneration
- Nosebleeds Retinal hemorrhages
- Loss of vision / blindness Other

Skin / Integument:

- I have no history of skin problems / disorders
- Skin cancer Rosacea
- Melanoma Skin breakdown / ulcers
- Skin cancer surgery Varicose veins
- Rashes Veinous isufficiency
- Excema Lymphedema, chronic swelling
- Psoriasis Acne

Behavior / Mood / Psychological

- I have no history mood problems / disorders
- Depression Alcoholism
- Bipolar Drug use / addiction
- Manic Other

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Past Surgeries / Invasive Procedures

<input type="checkbox"/> I have had no surgeries or invasive procedures					
Surgery		Date	Surgery		Date
<input type="checkbox"/>	Gallbladder		<input type="checkbox"/>	Tonsils	
<input type="checkbox"/>	Appendix		<input type="checkbox"/>	Hernia	
<input type="checkbox"/>	Thyroid		<input type="checkbox"/>	Hemorrhoids	
<input type="checkbox"/>	Cardiac catheterization		<input type="checkbox"/>	Splenectomy	
<input type="checkbox"/>	Cardiac Stents		<input type="checkbox"/>	Colonoscopy	
<input type="checkbox"/>	Cardiac Bypass		<input type="checkbox"/>	EGD endoscopy, upper	
<input type="checkbox"/>	Other cardiac surgery		<input type="checkbox"/>	Colon surgery	
<input type="checkbox"/>	Breast / Right		<input type="checkbox"/>	Colostomy	
<input type="checkbox"/>	Breast / Left		<input type="checkbox"/>	Colonoscopy	
<input type="checkbox"/>	Hysterectomy/ total		<input type="checkbox"/>	Other abdominal surgery	
<input type="checkbox"/>	Hysterectomy / partial		<input type="checkbox"/>	Lung Surgery	
<input type="checkbox"/>	Tubal ligation		<input type="checkbox"/>	Lithotripsy	
<input type="checkbox"/>	Laparoscopy		<input type="checkbox"/>	Open kidney stones	
<input type="checkbox"/>	Other female surgery		<input type="checkbox"/>	Vasectomy	
<input type="checkbox"/>	Bladder repair		<input type="checkbox"/>	Prostate biopsy	
<input type="checkbox"/>	Vascular bypass		<input type="checkbox"/>	Prostate resection	
<input type="checkbox"/>	Carotid		<input type="checkbox"/>	Prostate shrink	
<input type="checkbox"/>	Cystoscopy		<input type="checkbox"/>	Prostate seed	
<input type="checkbox"/>	Nose surgery		<input type="checkbox"/>	Kidney surgery	
<input type="checkbox"/>	Ear Surgery		<input type="checkbox"/>	Cataract <input type="checkbox"/> R <input type="checkbox"/> L	
<input type="checkbox"/>	Carpal tunnel Right		<input type="checkbox"/>	Corneal surgery	
<input type="checkbox"/>	Carpal Tunnel Left		<input type="checkbox"/>	Other Right Hand	
<input type="checkbox"/>	Shoulder, Right		<input type="checkbox"/>	Other Left Hand	
<input type="checkbox"/>	Elbow, Right		<input type="checkbox"/>	Shoulder Left	
<input type="checkbox"/>	Wrist, Right		<input type="checkbox"/>	Elbow Left	
<input type="checkbox"/>	Fingers Right		<input type="checkbox"/>	Wrist, Left	
<input type="checkbox"/>	Hip, Right		<input type="checkbox"/>	Fingers Left	
<input type="checkbox"/>	Knee Right		<input type="checkbox"/>	Hip, Left	
<input type="checkbox"/>	Ankle Right		<input type="checkbox"/>	Knee, Left	
<input type="checkbox"/>	Foot / Toes Right		<input type="checkbox"/>	Ankle, Left	
<input type="checkbox"/>	Radiation treatments		<input type="checkbox"/>	Foot / Toes Left	
<input type="checkbox"/>	Other surgery			Chemotherapy	

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Social History

Marital Status

- Single
 Married
 Divorced
 Widowed
 Separated

Use of Alcohol

- Never
 Rarely
 Moderate
 Daily

Use of Tobacco

- Never
 Quit
 Currently
 ____ packs/ day

Living Situation

- Alone
 With family
 Home Help
 Facility

Family History: Medical information pertaining to blood relatives:

Mother Alive Unknown

Deceased Age at death: _____

Cause of death _____

Father Alive Unknown

Deceased Age at death: _____

Cause of death _____

Medical conditions in blood relatives:

Mark an "X" only in boxes that apply. Leave all other boxes blank.

Condition	Mother	Father	Brother / Sister	Other blood relative
Death before age 50	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart attack	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Breast cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologic disorder	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Uterine cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ovarian cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Serious reaction to anesthesia other than nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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General System review:

General health

- Bad general health
- Recent weight gain
- Recent weight loss
- Fever
- Fatigue
- Headaches

Cardiovascular

- Heart trouble
- Chest pain. Angina
- Irregular heart beat
- Short of breath
- Swelling of feet
- Unable to climb 4 stairs

Respiratory

- Chronic cough
- Blood in sputum
- Shortness of breath
- Wheezing

Gastrointestinal

- Loss of appetite
- Nausea / vomiting
- Frequent diarrhea
- Constipation
- Rectal bleeding
- Abdominal pain

Endocrine

- Excessive thirst, urination
- Heat, cold intolerance
- Skin becoming dry

Musculoskeletal

- Joint pain
- Joint stiffness, swelling
- Weak muscles. joints
- Muscle pain, cramps
- Back pain
- Cold extremities
- Difficulty walking

Genitourinary

- Frequent urination
- Burning urination
- Blood in urine
- Incontinence / dribbling
- Decrease force / stream
- Male: discharge
- Male: testicle pain
- Female: painful periods
- Female vaginal discharge

Eyes

- Eye disease / injury
- Glasses / contact lens
- Blurred vision
- Double vision

Blood, Lymph

- Slow healing of cuts
- Bleeding tendency
- Bruise easily
- Anemia
- Enlarged glands
- Night Sweats

Psychiatric

- Memory loss / confusion
- Nervousness
- Depression
- Insomnia

Neurological

- Dizzy, lightheaded
- Numbness / tingling
- Tremors
- Paralysis

Skin, Breast

- Rash / itching
- Change in skin color
- Varicose veins
- Breast pain
- Breast lump

Ear, Nose, Throat

- Hearing loss, ringing
- Earaches, drainage
- Chronic sinus problem
- Nosebleeds
- Bleeding gums
- Sore throat
- Swollen neck glands

Dental

- Appliances
- Caries
- Dentures

- Other: Any other condition you are concerned about:

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Preventive Health:

Enter year and result for tests that you have had. Make no marks for tests that do not apply to you.

Test	Year	Result
Bone density		
Cholesterol / Triglycerides		
Colonoscopy		
Stool blood screening		
Rectal exam		
Female		
Breast exam		
Mammogram		
Pap smear		
Pelvic exam		
Male		
PSA		
Immunizations (shots)		
Tetanus		
Influenza (flu)		
Pneumococcal (pneumonia)		

Doctors taking care of me:	
Specialty	Name of Doctor
Primary	

Done