Information about your health is needed by your doctor to understand your medical problems and to get to know you a little better as a person. This information will remain confidential (private) and will be available to your doctor only.

**Hospitalizations and Surgeries**
List the year, name of the hospital, and the location by city and state, where you were hospitalized or had any surgical procedures done. Include procedures like tonsillectomy/adenoidectomy, appendectomy, gallbladder removal, hemorrhoid removal, hysterectomy (uterus or womb removal), and D&C (dilatation and curettage).

<table>
<thead>
<tr>
<th>Year</th>
<th>Hospital/City and State</th>
<th>Reason for hospitalization or type of surgery performed</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Medications**
List any medicines that you use often or every day. Under dosage, list how much you are taking in either milligrams (mg) or number of pills per dose. Under how often, list how many times a day you take the medicine. Be sure to include medicines like tylenol, aspirin, antacids, laxatives, sleeping pills, cold medicines, antibiotics (penicillin, sulfa, etc.), codeine, diet pills, vitamins, sedatives (nerve pills), and birth control pills.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Dosage</th>
<th>How often</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>8.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>9.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>10.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Allergies**
List any medicine, food, plants, animals, or other products that you are allergic to.
**Review of Systems (please check ✓ the box next to any illnesses or problems that apply to you)**

### I. General
- □ change in weight (recent)
- □ change in appetite (recent)
- □ weakness or fatigue (recent)
- □ bad nerves or tension
- □ crying for no reason
- □ depression
- □ poor memory
- □ suicidal

### Glands
- □ thyroid disease
- □ goiter
- □ sugar diabetes
- □ obesity

### Lungs
- □ asthma
- □ emphysema
- □ pneumonia
- □ tuberculosis (TB)
- □ pleurisy
- □ bronchitis
- □ hay fever
- □ nagging cough
- □ coughing up blood

### Heart
- □ angina (heart pains)
- □ high blood pressure
- □ heart attack
- □ heart failure (enlarged heart)
- □ rheumatic fever
- □ chest pain
- □ racing heart or palpitations
- □ shortness of breath
  - with work or exertion

### Blood Vessels
- □ varicose veins
- □ blood clots in leg (phlebitis)
- □ blood clots in lung
- □ leg pain with work or exertion
- □ swelling in feet or ankles

### Blood
- □ high cholesterol
- □ anemia
- □ bleeding problems
- □ blood transfusion
- □ sickle cell disease or trait

### Infections
- □ chicken pox
- □ mononucleosis

### Abdomen
- □ ulcer or stomach bleeds
- □ hepatitis (yellow jaundice)
- □ cirrhosis
- □ pancreatitis
- □ gallstones
- □ gallbladder infection
- □ polyps in colon
- □ hemorrhoids
- □ hernias
- □ diverticulosis
- □ trouble swallowing
- □ constipation
- □ black, tarry, or bloody stools

### Kidney
- □ kidney stones
- □ kidney or bladder infection
- □ other kidney disease
- □ unable to control urination
- □ frequent urination

### Eyes
- □ eczema
- □ hives/rashes
- □ acne
- □ skin cancer
- □ change in mole size

### Head and Nervous System
- □ migraine or severe headaches
- □ stroke
- □ seizures/epilepsy/convulsions
- □ polio
- □ nervous or emotional problems
- □ concussion
- □ meningitis
- □ loss of consciousness or blackouts
- □ dizziness
- □ numbness, tingling, or burning in hands or feet

### Skin
- □ eczema
- □ hives/rashes
- □ acne
- □ skin cancer
- □ change in mole size

### Ears
- □ deafness or trouble hearing
- □ ringing in ears
- □ chronic infections

### Eyes
- □ change in eyesight
- □ glaucoma
- □ cataracts
- □ blindness

### Bones and Joints
- □ arthritis or rheumatism
- □ gout
- □ broken bones (which ones?)
- □ scoliosis

### Other
- □ cancer-type
- □ hoarseness (recent)
- □ other diseases

### II. For Males Only
- □ enlarged prostate
- □ difficulty starting or stopping urine flow

Do you perform testes self-examination? □ Yes □ No

### III. For Females Only (please check ✓ appropriate box or fill in blank)

How old were you when periods first started? □ 9 □ 10 □ 11 □ 12 □ 13 □ 14 □ 15 □ 16 □ 17 □ 18 years

How often are the periods? approximately every □ 3 weeks □ 4 weeks □ 5 weeks □ Other

How many days do the periods last? □ 1 □ 2 □ 3 □ 4 □ 5 □ 6 □ 7 □ more than 7

Have you had menopause (Change of life)? □ Yes □ No □ If Yes, what year?

Do you use contraception? □ Yes □ No □ If Yes, what type?

Do you perform breast self-examination? □ Yes □ No

Date of last menstrual period _____________

Have you had venereal or pelvic infections? □ Yes □ No

Last PAP smear: Date _____________ Doctor’s name ___________________ Results ___________________

Number of pregnancies _____________ Number of living children _____________

Number of abortions _____________ Number of miscarriages _____________

- □ discharge from nipples
- □ pain with intercourse
- □ lumps in breast
- □ unexpected vaginal bleeding
- □ decreased interest in sex
- □ bleeding after intercourse
X-Rays/Immunizations/Other Tests
List the year that any of the following were performed.

<table>
<thead>
<tr>
<th>X-Ray</th>
<th>Year</th>
<th>Immunizations/Other Tests</th>
<th>Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chest</td>
<td></td>
<td>EKG <em>(heart tracing or cardiogram)</em></td>
<td></td>
</tr>
<tr>
<td>Breast <em>(mammography)</em></td>
<td></td>
<td>Prostate Specific Antigens</td>
<td></td>
</tr>
<tr>
<td>Stomach <em>(upperGI)</em></td>
<td></td>
<td>Sigmoidoscopy</td>
<td></td>
</tr>
<tr>
<td>Gallbladder</td>
<td></td>
<td>Tetanus vaccination</td>
<td></td>
</tr>
<tr>
<td>Colon <em>(Barium Enema)</em></td>
<td></td>
<td>Pneumococcal vaccination</td>
<td></td>
</tr>
<tr>
<td>Kidney <em>(IVP)</em></td>
<td></td>
<td>Flu vaccination</td>
<td></td>
</tr>
<tr>
<td>Back</td>
<td></td>
<td>Rubella vaccination</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Hepatitis vaccination</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td></td>
<td>Tuberculosis skin test</td>
<td></td>
</tr>
<tr>
<td>Bone density</td>
<td></td>
<td>Vision test <em>(eye exam)</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hearing test</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Urinalysis <em>(urine test)</em></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dental check-up</td>
<td></td>
</tr>
</tbody>
</table>

Family History
Answer or check mark (✓) the appropriate item listed across the top row for each respective relative. Under brothers, sisters, and grandparents list only **blood** relationships.

<table>
<thead>
<tr>
<th>Family Member</th>
<th>Age</th>
<th>If deceased, age and cause of death</th>
<th>Cancer (type)</th>
<th>Diabetes</th>
<th>Kidney disease</th>
<th>Heart disease</th>
<th>Heart attack</th>
<th>Stroke</th>
<th>High blood pressure</th>
<th>Arthritis</th>
<th>Gout</th>
<th>Seizures/Epilepsy</th>
<th>Bleeding problems</th>
<th>Anemia</th>
<th>Sickle cell problems</th>
<th>Thalassemia</th>
<th>Anemia</th>
<th>Alcoholism</th>
<th>Nervous problems</th>
<th>Mental illness</th>
<th>Glaucoma</th>
<th>Migraines</th>
<th>Other</th>
<th>Other</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Father</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Mother</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Brothers and Sisters</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other blood relatives with medical problems (grandparents, aunts, uncles, etc)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Remarks
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

Please list all health care providers and their specialty *(eg, Dr. Jones – Neurology)*.
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

*Please turn the page*
Social/Lifestyle History

Please answer the following questions. (where indicated, check (✓) appropriate response)

1. Are you? □ Married □ Single □ Divorced □ Separated □ Widowed □ Partner

2. Who lives in your house? ________________________________

3. Are there any members in the household who are disabled, or bedridden? □ Yes □ No
   If Yes, who? ________________________________

4. Are there many stresses at home? □ Yes □ No  At work? □ Yes □ No

5. Tobacco use (check those tobacco products that you have ever used regularly)
   □ Cigarettes  □ Pipe  □ Cigars  □ Chewing tobacco  □ Snuff  □ None

   What is the average number of packs of cigarettes that you smoke or used to smoke per day?
   □ None  □ less than \(\frac{1}{2}\)  □ \(\frac{1}{2}\) – 1  □ 1 – 2  □ 2 or more

   How many years have you smoked?  □ 0  □ 5  □ 10  □ 15  □ 20  □ 25  □ 30  □ 35  □ 40  □ more than 40

   Do you still smoke? □ Yes □ No  If you have permanently quit, when? ________________________________

6. Alcohol use
   Have you ever had a problem with drinking alcohol? □ Yes □ No

   Has anyone close to you ever thought you drank too much? □ Yes □ No

   How often do you or did you drink beer, wine, or whiskey?
   □ Never  □ Rarely  □ Once a week  □ Several times a week  □ Daily

   Number of 12 ounce cans of beer consumed a week ________________________________

   Number of 8 ounce glasses of wine consumed a week ________________________________

   Number of shots (shot = \(\frac{1}{2}\) ounces) of liquor consumed per week ________________________________

   Do you still drink? □ Yes □ No  If you have permanently quit, when? ________________________________

7. Do you sometimes use marijuana or other drugs socially? □ Yes □ No

8. How many cups of coffee, tea, or cola do you drink per day? □ None  □ 1 – 2  □ 3 – 6  □ 7 or more

9. Are you on a special diet? □ Yes □ No  If Yes, what kind? ________________________________

10. How often do you exercise? □ Never  □ Rarely  □ Once a week  □ Several times a week  □ Daily

     What kind of exercises ________________________________

11. Do you have difficulty falling asleep or awakening early? □ Yes □ No □ Sometimes

12. What kind of work do you do? ________________________________

     Are you working now? □ Yes □ No

     Which of the following are you exposed to at work
     □ Excessive noise  □ Fumes  □ Air pollution
     □ Poisons and Chemicals  □ Crowded conditions

13. Do you have a Living Will? □ Yes □ No

14. You are not required to answer the following questions, however, the answers may help your doctor give you a better advice and treatment.

   A. Do you find your sexual life to be satisfactory? □ Yes □ No □ Sometimes

      What is your sexual preference? □ Heterosexual (opposite sex only)  □ Homosexual  □ Bisexual

      Do you have more than one sexual partner per year? □ Yes □ No

   B. Do you have a specific religion? □ Yes ________________________________ □ No

   C. Did/do you use alternative health providers/treatments, such as: accupuncture, natural remedies (Chinese herbs), or homeopathy? □ Yes □ No  If Yes, explain ________________________________

Reviewed ________________________________

Patient Signature ________________________________

(page 4 of 4)