

NAME \_\_\_\_\_

DATE \_\_\_\_\_

ADDRESS \_\_\_\_\_

PHONE (H) \_\_\_\_\_ (O) \_\_\_\_\_

OCCUPATION / EMPLOYER \_\_\_\_\_ STUDENT: FT PT N/A

INSURANCE # \_\_\_\_\_

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER & INDICATE WHICH RELATIVE

- |                |                   |                   |                |       |
|----------------|-------------------|-------------------|----------------|-------|
| 1) EPILEPSY    | 6) THYROID        | 11) OSTEOPOROSIS  | 16) ALCOHOLISM | _____ |
| 2) MIGRAINE    | 7) HAYFEVER       | 12) ARTHRITIS     | 17) CANCER     | _____ |
| 3) MENTAL ILL. | 8) ASTHMA         | 13) HEART DISEASE | 18) _____      | _____ |
| 4) GLAUCOMA    | 9) ANEMIA         | 14) STROKE        | 19) _____      | _____ |
| 5) DIABETES    | 10) BLEEDS EASILY | 15) HYPERTENSION  |                | _____ |

HOSPITAL ADMISSIONS not including pregnancies

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST ALL MEDICATIONS YOU ARE NOW TAKING

ALLERGIES

VACCINE

TEST/EXAM

_____	_____	TETANUS/Td	RECTAL / STOOL
_____	_____	FLU	CHOLESTEROL
_____	_____	PNEUMONIA	EYE
_____	_____	HEPATITIS	
_____	_____	TUBERCULOS	

MEDICAL HISTORY Mark (C) for current problems. Check (if) and indicate age when you had any of the following symptoms or diseases.

MAIN PROBLEMS 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

- |  |  |   |  |   |  |
|--|--|---|--|---|--|
| <input type="checkbox"/> Decreased Hearing                               | <input type="checkbox"/> Loss of Appetite-Recent   | <input type="checkbox"/> Cancer                                     | <input type="checkbox"/> Chicken Pox   | <input type="checkbox"/> Polio          | <input type="checkbox"/> Mumps           |
| <input type="checkbox"/> Ringing in Ear                                  | <input type="checkbox"/> Difficulty Swallowing   | <input type="checkbox"/> Diabetes                                   | <input type="checkbox"/> Measles   | <input type="checkbox"/> German Measles | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Ear Infections - frequent                       | <input type="checkbox"/> Indigestion or Heartburn  | <input type="checkbox"/> Thyroid Disease                            | <input type="checkbox"/> Scarlet Fever   | <input type="checkbox"/> Tuberculosis   | <input type="checkbox"/> Herpes          |
| <input type="checkbox"/> Dizzy Spells                                    | <input type="checkbox"/> Persistent Nausea / Vomiting  | <input type="checkbox"/> Convulsions / Seizures                     | <input type="checkbox"/> Contact with Blood or Body Fluids   |   |  |
| <input type="checkbox"/> Failing Vision D Eye Pain                       | <input type="checkbox"/> Peptic Ulcers   | <input type="checkbox"/> Stroke                                     |  |   |  |
| <input type="checkbox"/> Double or Blurred Vision                        | <input type="checkbox"/> Abdominal Pain- chronic   | <input type="checkbox"/> Tremor / Hands Shaking                     | <input type="checkbox"/> Alcohol _____ oz. per week  |   |  |
| <input type="checkbox"/> Eye Infections - frequent                       | <input type="checkbox"/> Gall Bladder Trouble  | <input type="checkbox"/> Muscle Weakness                            | <input type="checkbox"/> Smoking _____ cig. per day _____ #yrs.                                      |   |  |
| <input type="checkbox"/> Nose Bleeds - recurrent                         | <input type="checkbox"/> Jaundice / Hepatitis  | <input type="checkbox"/> Numbness / Tingling                        | <input type="checkbox"/> Coffee / Tea _____ cups per day   |   |  |
| <input type="checkbox"/> Sinus Trouble                                   | <input type="checkbox"/> Change in Bowel Habits  | Sensations  |  |   |  |
| <input type="checkbox"/> Sore Throats - frequent                         | <input type="checkbox"/> Diarrhea D Constipation   | <input type="checkbox"/> Headaches - frequent                       | <b>FEMALES - Please complete</b>   |   |  |
| <input type="checkbox"/> Hayfever / Allergies                            | <input type="checkbox"/> Diverticulosis D Crohn's / Colitis  | <input type="checkbox"/> Arthritis / Rheumatism                     | Menstrual Flow:  |   |  |
| <input type="checkbox"/> Hoarseness - prolonged                          | <input type="checkbox"/> Bloody or Tarry Stools  | <input type="checkbox"/> Back Pain - recurrent                      | <input type="checkbox"/> Reg. <input type="checkbox"/> Irreg. <input type="checkbox"/> Pain / Cramps |   |  |
| <input type="checkbox"/> Pneumonia / Pleurisy                            | <input type="checkbox"/> Hemorrhoids   | <input type="checkbox"/> Bone Fracture / Joint Injury               | Days of Flow _____ Length of Cycle _____   |   |  |
| <input type="checkbox"/> Bronchitis / Chronic Cough                      | <input type="checkbox"/> Hernia  | <input type="checkbox"/> Gout <input type="checkbox"/> Osteoporosis | Date -1 st day of last period _____  |   |  |
| <input type="checkbox"/> Asthma / Wheezing                               | <input type="checkbox"/> Urine Infections - frequent   | <input type="checkbox"/> Foot Pain                                  | <input type="checkbox"/> Pain / Bleeding during or after sex   |   |  |
| <input type="checkbox"/> Shortness of Breath:                            | <input type="checkbox"/> Blood in Urine  | <input type="checkbox"/> Cold Numb Feet                             | Number of:   |   |  |
| <input type="checkbox"/> on Exertion <input type="checkbox"/> Lying Flat | <input type="checkbox"/> Urination _____ Overnight, > than twice _____ Painful _____ Loss of Control | <input type="checkbox"/> Rashes <input type="checkbox"/> Hives      | Pregnancies _____ Abortions _____  |   |  |
| <input type="checkbox"/> Chest Pain                                      | <input type="checkbox"/> Decrease in Force / Flow  | <input type="checkbox"/> Psoriasis <input type="checkbox"/> Eczema  | Miscarriages _____ Live Births _____   |   |  |
| <input type="checkbox"/> High Blood Pressure                             | <input type="checkbox"/> Kidney Stones   | <input type="checkbox"/> Sleeping - difficulty                      | Birth Control Method _____   |   |  |
| <input type="checkbox"/> Heart Murmur                                    | <input type="checkbox"/> Venereal Disease  | <input type="checkbox"/> Nervousness                                | B.C. Pill (name) _____   |   |  |
| <input type="checkbox"/> Irregular Pulse                                 | <input type="checkbox"/> Urethral Discharge  | <input type="checkbox"/> Depression                                 | <input type="checkbox"/> Flushing / Menopause  |   |  |
| <input type="checkbox"/> Palpitations                                    | <input type="checkbox"/> Chronic Fatigue   | <input type="checkbox"/> Memory Loss                                | Date of last PAP Test _____  |   |  |
| <input type="checkbox"/> Swollen Ankles                                  | <input type="checkbox"/> Weight Loss - recent  | <input type="checkbox"/> Moodiness - excessive                      | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal                                    |   |  |
| <input type="checkbox"/> Fainting Spells                                 | <input type="checkbox"/> Anemia <input type="checkbox"/> Bruise Easily                               | <input type="checkbox"/> Phobias                                    | Date of last Mammogram _____   |   |  |
| <input type="checkbox"/> Leg Pain - walking                              |  | <input type="checkbox"/> Mental Illness                             | <input type="checkbox"/> Normal <input type="checkbox"/> Abnormal                                    |   |  |
| <input type="checkbox"/> Varicose Veins / Phelbitis                      |  |   |  |   |  |

SYNOPSIS

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