PATIENT NAME_____ **CHART#**_____

FATHER: List any health problems _____

If deceased, list cause _____

MOTHER: List any health problems _____

If deceased, list cause _____

SPOUSE: List any health problems _____

If deceased, list cause _____

BROTHERS: List any health problems _____

If deceased, list cause _____

SISTERS: List any health problem _____

If deceased, list cause _____

CHECK ILLNESSES WHICH HAVE OCCURRED IN ANY OF YOUR BLOOD RELATIVES

___ Diabetes ___ Allergy ___ Kidney Disease ___ Tuberculosis ___ Nervous Illness
___ Cancer ___ Stroke ___ Bleeding Tendency ___ Heart Disease ___ High Blood Pressure
___ Other_____

CHECK ANY ILLNESSES OR CONDITIONS YOU HAVE HAD

___ Diabetes ___ Glaucoma ___ Bleeding Tendency ___ Kidney Disease ___ Tuberculosis
___ Asthma ___ Jaundice ___ Thyroid Disease ___ Skin Disorders ___ Heart Trouble
___ Seizures ___ Cataracts ___ Pneumonia ___ Cancer ___ Vein Trouble
___ Swollen Lymph Glands ___ Urination Difficulty ___ Other_____

LIST OTHER ILLNESSES NOT REQUIRING SURGERY FOR WHICH YOU WERE HOSPITALIZED

_____

HAVE YOU HAD SERIOUS INJURIES, BROKEN BONES, ETC?

___ YES ___ NO LIST:_____

HAVE YOU HAD ALLERGY OR SENSITIVITY TO MEDICINES OR OTHER SUBSTANCES?

___ YES ___ NO LIST:_____

HAVE YOU USED RECREATIONAL DRUGS? _____ TYPE/DAILYAMOUNT:_____
DO YOU USE TOBACCO ?_____ TYPE /DAILY AMOUNT _____ HOW LONG_____
DO YOU USE ALCOHOL? _____ TYPE /DAILY AMOUNT _____ HOW LONG _____

PREVIOUS SURGERIES/YEAR: _____

DENTAL (LIST SIGNIFICANT PROBLEMS): _____

LIST MEDICATIONS YOU ARE NOW USING:_____

NUTRITIONAL SUPPLEMENTS: _____

PLEASE COMPLETE REVERSE SIDE

HAVE YOU HAD X-RAYS/ MRI/ CT SCAN: _____ RESULTS: _____

_____

CHECK ALL THAT APPLY: ____ FATIGUE ___ TROUBLE SLEEPING ___ MOOD CHANGES ___ WEIGHT LOSS OR ____ WEIGHT GAIN IN LAST 6 MO. HOW MUCH? _____

DO YOU EXERCISE? _____ WHAT ACTIVITIES DO YOU DO? _____

DO YOU HAVE : ____ VERTIGO OR DIZZINESS ____ CONTACTS/ GLASSES ____ TROUBLE SWALLOWING ____CHANGE IN TASTE/ SMELL ____ HEARING LOSS ____ RINGING EARS ____ HEADACHES
HOW OFTEN _____ WHERE LOCATED_____
HOW SEVERE _____

DO YOU HAVE: ____ ABDOMINAL PAIN ____ HEARTBURN ____ INDIGESTION ____ DIARRHEA ____ CONSTIPATION ____NAUSEA ____ VOMITING

BRIEFLY EXPLAIN WHY YOU CAME TODAY: _____

_____

_____

_____

IF YOU HAVE LOW BACK PAIN: WHEN DOES IT HURT _____

WHAT MAKES IT BETTER_____

WHEN DID IT START _____ DOES IT GO DOWN EITHER LEG _____

DO YOU HAVE NUMBNESS/TINGLING _____

IF YOU HAVE RIBCAGE/UPPER BACK PROBLEMS: WHEN DOES IT HURT _____

WHAT MAKES IT BETTER _____

WHEN DID IT START _____

DOES YOUR CHEST HURT_____

DO YOU HAVE KNEE/ANKLE/FOOT PROBLEMS:_____ DESCRIBE_____

DO YOU HAVE ARM/ELBOW/WRIST/HAND PROBLEMS: _____ DESCRIBE_____

DO YOU HAVE NECK/SHOULDER PROBLEMS: _____ DESCRIBE_____

THIS SECTION FOR WOMEN ONLY

BREAST DISORDERS? _____ CRAMPS? _____ PROBLEM BECOMING PREGNANT?_____

HOW MANY CHILDREN? _____ PROBLEMS WITH CHILDBIRTH? _____ MISCARRIAGES? _____

THIS SECTION FOR MEN ONLY

ANY KNOWN PROSTATE PROBLEMS/URINATION/SEXUAL DYSFUNCTION: _____

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**