

Patient Name: _____ DOB: _____ Current Problem: _____

Please circle any of the following you have experienced.

General

Chills	Headache	Nervousness	Phobias	Fainting	Moodiness	Cancer
Depression	Loss of sleep	Confusion	Mental illness	Fever	Thyroid disease	Stroke
Dizziness	Unusual weight change	Hand tremor	Diabetes	Sweats	Numbness	

Muscle/Joint/Bone

Pain/weakness/numbness. Explain: _____

Bone Fracture	Joint injury	Gout	Pain with walking	Chronic fatigue	Arthritis	Rheumatism
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Genito-Urinary

Blood in Urine	Frequent Urination	Lack of bladder control	Painful urination	Frequent urinary infections
Kidney stones	Urethral discharge			

Gastrointestinal

Poor appetite	Bloating	Bowel changes	Constipation	Diarrhea	Excessive hunger	Hemorrhoids
Abdominal Pain	Nausea	Rectal Bleeding	Vomiting	Hepatitis	Excessive thirst	Heartburn
Stomach pain	Gas	Gall Bladder	Diverticulitis	Hernia	Peptic Ulcers	Indigestion

Cardiovascular

Chest pain	High Blood pressure	Low Blood Pressure	Irregular heart beat	Poor circulation	Palpitations
Asthma	Wheezing	Heart Murmur	Varicose veins	Short of Breath	

Eye, Ear, Nose, Throat

Bleeding gums	Vision problems	Difficulty swallowing	Nose Bleed	Ear discharge	Hay fever	Pneumonia
Hearing loss	Persistent cough	Hoarseness, Prolong	Bronchitis	Ringing ears	Allergies	Pleurisy
Eye pain	Sinus problems	Frequent eye infection	Frequent sore throat	Ear ache		

Skin

Bruising	Hives	Rash	Itching	Change in moles	Sore won't heal	Jaundice	Psoriasis	Eczema	Anemia
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Communicable diseases

Polio	Measles	Scarlet fever	Sex-Trans-Disease	Mumps	Tuberculosis	Rheumatic fever	Chicken Pox
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Men and Women

Date of last colonoscopy	_____	Last physical exam	_____
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Men Only

Breast Lump	Erection difficulties	Lump in testicles	Penis discharge	Sores	Other: _____
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Women only

Abnormal pap smear	Vaginal discharge	Breast lump	Menopause	Other: _____	
Extreme menstrual pain	Hot Flashes	Painful intercourse	Nipple discharge	Bleeding between periods	
Date of last menstrual period	_____	Last pap smear	_____	Last mammogram	_____
Are you pregnant?	Y N	Number of pregnancies	_____	Number of children	_____

I certify that the above information is correct to the best of my knowledge. I will not hold my care provider or any member of the staff responsible for errors or omissions that I may have made in the completion of this form.

Patient Signature

Date

Provider Signature

Date

Name Label

Initial/Date

Initial/Date