

MEDICATION ALLERGIES:

List all medications that you are allergic to or don't tolerate. Please describe the reaction (rash, swelling, nausea):

REVIEW OF SYSTEMS

Please check the symptoms you are currently experiencing or have recently experienced.

GENERAL:

- Excessive sleepiness
- Sleeplessness (Insomnia)
- Fever
- Night sweats/hot flashes
- Weight gain
- Weight loss
- Loss of appetite
- Fatigue

SKIN:

- Rash
- Dryness
- Nail problems
- Itching
- Hair problems
- Lumps/Wart or mole changes
- Bruises

HEAD-EYES-EARS-NOSE-THROAT:

- Double vision/blurry vision
- Diminished vision
- Itchy eyes
- Hearing loss/ wearing hearing aides
- Ear clogging
- Ringing in ears
- Jaw pain/ TMJ
- Sinus congestion/ Stuffy nose
- Nasal drip (runny nose)
- Bloody nose
- Hoarseness
- Sore throat

NODES AND GLANDS:

- Swollen/Painful glands
- Excessive thirst
- Cold intolerance
- Heat intolerance

BREASTS:

- Lumps or cysts
- Breast pain prior to menstruation
- Nipple discharge

LUNGS:

- Shortness of breath
- Chronic cough
- Coughing up blood

CARDIOVASCULAR:

- Chest discomfort
- Irregular pulse (skip beats)
- Leg pain with walking
- Swelling in feet or ankles
- Dizziness or fainting spells
- Decreased exercise tolerance

GASTROINTESTINAL:

- Difficulty swallowing/ pain with swallowing
- Heartburn
- Nausea
- Vomiting
- Abdominal pain
- Diarrhea
- Constipation
- Hemorrhoids
- Blood in stool

GENITO-URINARY:

- Loss of bladder control (incontinence)
- Blood in urine
- Pain/Burning with urination
- Increase frequency of urination
- Awakening at night to urinate

MUSCULOSKELETAL:

- Muscle weakness
- Joint pain/swelling/stiffness
- Difficulty walking due to joint or muscle pain
- Leg cramps

NEUROLOGICAL/PSYCHIATRIC:

- Memory loss
- Loss of coordination
- Numbness/tingling
- Headache
- Loss of balance
- Anxiety
- Depression

MEN ONLY:

- Are you currently/recently sexually active?
- Decreased sex drive/Low libido
- Difficulty getting an erection or maintaining an erection
- Difficulty starting to urinate
- Feeling of incomplete bladder emptying
- Dribbling after urination
- Decreased urinary stream
- Discharge from penis

WOMEN ONLY:

- How old were you when your period started?
- If you still get your period:
 - Date last menstrual cycle began:
 - Are your Periods regular?
 - Do you get painful menstrual cramps?
 - How long does your period last?
 - Do you get spotting between Periods?
- Are you currently sexually active?
- Pain with Intercourse?
- Loss of sex drive/Other sexual difficulties
- Do you use any type of Birth Control? What Type?
- Have you gone through menopause? Age at Menopause?
- Have you tried to get pregnant unsuccessfully?
- Have you sought care for infertility?
- Number of pregnancies:
- Numbers of live births:
- Numbers of miscarriages:
- Numbers of abortions:

SOCIAL HISTORY:

- Do you drink beverages containing caffeine? _____
- If so, what do you drink and how often? _____
- Do you smoke? _____
- Did you smoke in the past? _____
- If so, how many packs a day for how many years? _____
- Do you drink alcohol? _____
- If so, how much and how often _____
- Do you use illegal recreational drugs? _____

Have you used illegal recreational drugs in the past? _____

What do you do for exercise? _____

Describe your diet: _____

If you are working, what sort of work do you do? _____

PREVENTION

Vaccinations

Date of most recent

Tetanus (every 10 years)

Pertussis/Tetanus (Tdap/Adacel once in adulthood)

Pneumonia (once if over 65)

Shingles (Zostavax) (once if over 60)

Colonoscopy (over 50, sooner if family history)

Women only

Papsmear/gyn exam

Bone density test (dexa; for postmenopausal)

Mammogram

Where have you gone for medical care in the past year?

For example:

ER (emergency room)/Urgent Care

Cardiologist

Dermatologist

Eye doctor (ophthalmologist)

Gynecologist

Neurologist

Orthopedist

Urologist

Others:

Please list any surgeries you have had (even surgeries done years ago):

Date Type of surgery

In the past or currently do you have any of the following health conditions?

- Cancer
- Anemia
- Difficulty clotting
- Sickle Cell Anemia
- Thalassemia
- Overactive Thyroid (hyperthyroidism)
- Underactive Thyroid (hypothyroidism)
- Asthma
- Emphysema/COPD
- High blood pressure (hypertension)
- Fainting spells (syncope)
- Heart murmur
- Heart rhythm problem (ex atrial fibrillation)
- Heart valve problem
- Coronary Artery Disease/ Heart attack
- Varicose veins
- Hiatal hernia
- Ulcer
- Colitis
- Gallbladder disease
- Hepatitis
- Bladder or kidney infections (UTI)
- Kidney stones
- Gout
- Arthritis
- Seizures

Cataracts
Glaucoma
Anxiety
Depression
Obsessive compulsive disorder
Eating disorder

In addition to anything noted above please list any acute or chronic medical problems that interfere with your daily life.

<u>Year of Onset</u>	<u>Illness/ Condition</u>	<u>Treatments</u>
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FAMILY HISTORY: Please note major health problems of your parents, grandparents, siblings, and children. If you check a box please indicate which member of your family has or had the condition. If you know what members of your family died from please let me know.

Diabetes
Cancer
High blood pressure
High cholesterol
Heart attack
Stroke

THANK YOU FOR TAKING THE TIME TO FILL OUT THIS MEDICAL FORM. Please remember to bring this form to your visit.