Personal Medical History

Please answer every question.

Marking Instructions

- ***Use only a number 2 pencil.***
- ***Fill in the complete oval as shown . .*** 

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

PLEASE PRINT PATIENT'S DATE OF BIRTH

Month Day Year

DIRECTION OF FEED

YOUR Medical History

Please indicate if you have a history of the following:

- Alcoholism ○
- Anemia ○
- Anesthetic Complication ○
- Anxiety ○
- Abdominal Aortic Aneurysm ○
- Arrhythmia ○
- Arthritis ○
- Asthma ○
- Atrial Fibrillation ○
- Autoimmune Problems ○
- Bleeding Disorder ○
- Blood Clots ○
- Breast Cancer ○
- Cervical Cancer ○
- Colon Cancer ○
- Crohn's ○
- Depression ○
- Diabetes Insulin Dependant ○
- Diabetes Non-Insulin Dependant ○
- Dialysis ○
- Diverticulosis ○
- Fibromyalgia ○
- Gout ○
- Headaches ○
- Heart Attack ○
- Heart Disease ○
- High Blood Pressure ○
- High Cholesterol ○
- HIV ○
- Kidney Cancer ○
- Kidney Disease ○
- Kidney Stones ○
- Liver Cancer ○
- Liver Disease ○
- Lung / Respiratory Disease ○
- Lung Cancer ○
- Mental Illness ○
- Osteoporosis ○
- Ovarian Cancer ○
- Peptic Ulcer Disease ○
- Prostate Cancer ○
- Reflux / GERD ○
- Rectal Cancer ○
- Sexually Transmitted Disease ○
- Skin Cancer ○
- Stroke ○
- Suicide Attempt ○
- Thyroid Disease ○
- TIA ○
- Ulcerative Colitis ○
- None of the Above ○

FAMILY Medical History

Please indicate if your family has a history of the following:

	MOTHER	FATHER	SISTER	BROTHER	GRAND-PARENTS
Anemia	○	○	○	○	○
Anesthetic Problems	○	○	○	○	○
Autoimmune Disorder	○	○	○	○	○
Abnormal Bleeding Disorder	○	○	○	○	○
Blood Clotting Disorder	○	○	○	○	○
Breast Cancer	○	○	○	○	○
Colorectal Cancer	○	○	○	○	○
Dialysis	○	○	○	○	○
Diabetes	○	○	○	○	○
Heart Disease	○	○	○	○	○
High Blood Pressure	○	○	○	○	○
High Cholesterol	○	○	○	○	○
Kidney Disease	○	○	○	○	○
Kidney Cancer	○	○	○	○	○
Lung / Respiratory Disease	○	○	○	○	○
Lung Cancer	○	○	○	○	○
Prostate Cancer	○	○	○	○	○
Seizures / Convulsions	○	○	○	○	○
Stroke	○	○	○	○	○
Thyroid Disease	○	○	○	○	○
Brain Cancer	○	○	○	○	○
Melanoma	○	○	○	○	○
Ovarian Cancer	○	○	○	○	○
Pancreatic Cancer	○	○	○	○	○

Family Medical History Unknown → ○

ADDITIONAL HISTORY

Tobacco Use

- ○ current ○ quit ○ never — **How would you describe your use of tobacco products?**
- ○ less than 5 years
- ○ more than 5 years — **If quit, how long ago?**
- ○ less than 1/2 pack per day
- ○ 1 pack per day
- ○ more than 1 pack per day — **If current, how many packs per day?**

Alcohol Use

- ○ never
- ○ 1-2 times per week
- ○ 2-5 times per week
- ○ more than 5 times per week — **How often do you drink alcohol?**
- ○ 1-2 ○ 6-9
- ○ 3-5 ○ 10+ — **How many drinks per occasion?**
- ○ yes ○ no — **Did you formerly drink alcohol, but have permanently stopped?**

Drug Use

- ○ current ○ previous ○ none — **Illicit Drug Use**

HIV High Risk Behaviors

- ○ yes ○ no — **Have you participated in any of these HIV Risk Factor behaviors?** *IV drug use, currently more than one sexual partner, sex with a prostitute, unprotected sex, share contaminated needles*

Habits

- ○ yes ○ no — **Caffeine Use**
- ○ 1-2 ○ 6-9
- ○ 3-5 ○ 10+ — **Number of caffeine drinks per day:**
- ○ yes ○ no — **Do you exercise regularly?**

Review of Systems

Marking Instructions

- *Use only a number 2 pencil.*
- *Fill in the complete oval as shown . . .* 

DO NOT FOLD

PLEASE PRINT PATIENT'S LAST NAME

PLEASE PRINT PATIENT'S FIRST NAME

DIRECTION OF FEED

PLEASE PRINT PATIENT'S DATE OF BIRTH

Month Day Year

First Visit - ***Mark all symptoms that pertain to you.***

Repeat Visit - ***Mark only the symptoms that you have experienced since your last visit.***

*(Mark all that apply - **if no symptoms, please mark "NONE")***

General

fevers ○ chills ○ sweats ○
appetite loss ○ weight loss ○ "feeling sick" ○
fatigue (always tired) ○ **NONE** ○

Eyes

vision loss - 1 eye ○ double vision ○ eye irritation ○
vision loss - both eyes ○ blurring ○ eye pain ○
"halos" around lights ○ discharge ○ light sensitivity ○
NONE ○

Ears/Nose/Throat

ringing in the ears ○ ear discharge ○ earache ○
decreased hearing ○ nasal congestion ○ nosebleeds ○
difficulty swallowing ○ hoarseness ○ sore throat ○
NONE ○

Cardiovascular

difficulty breathing at night ○ near fainting ○ chest pain or discomfort ○
racing / skipping heart beats ○ fatigue ○ lightheadedness ○
shortness of breath with exertion ○ palpitations ○ swelling of hands or feet ○
difficulty breathing while lying down ○ fainting ○ leg cramps with exertion ○
bluish discoloration of lips or nails ○ weight gain ○ **NONE** ○

Respiratory

sleep disturbances due to breathing ○ cough ○ shortness of breath ○
coughing up blood ○ chest discomfort ○ wheezing ○
excessive sputum ○ excessive snoring ○ **NONE** ○

Gastrointestinal

excessive appetite ○ loss of appetite ○ indigestion ○
vomiting blood ○ nausea ○ vomiting ○
yellowish skin color ○ gas ○ abdominal pain ○
abdominal bloating ○ hemorrhoids ○ diarrhea ○
change in bowel habits ○ constipation ○ dark tarry stools ○
bloody stools ○ **NONE** ○

Please turn this card to continue on the other side. ▶

*(Mark all that apply - **if no symptoms, please mark "NONE")***

Genitourinary

- ○ urinary frequency
- ○ kidney pain
- ○ night time urination
- ○ lack of sexual drive
- ○ unusual urinary color
- ○ **NONE**
- ○ blood in urine
- ○ urinary urgency
- ○ painful urination
- ○ genital sores
- ○ missed periods
- ○ pelvic pain
- ○ foul urinary discharge
- ○ inability to empty bladder
- ○ trouble starting urinary stream
- ○ inability to control bladder
- ○ excessively heavy periods
- ○ other abnormal vaginal bleeding

Musculoskeletal

- ○ joint swelling
- ○ stiffness
- ○ gout
- ○ **NONE**
- ○ joint pain
- ○ back pain
- ○ arthritis
- ○ muscle aches
- ○ muscle cramps
- ○ presence of joint fluid
- ○ muscle weakness
- ○ loss of strength

Skin

- ○ suspicious lesions
- ○ poor wound healing
- ○ itching
- ○ rash
- ○ **NONE**
- ○ night sweats
- ○ dryness
- ○ skin cancer
- ○ flushing
- ○ excessive perspiration
- ○ changes in nail beds
- ○ unusual hair distribution
- ○ changes in color of skin

Neurologic

- ○ headaches
- ○ inability to speak
- ○ brief paralysis
- ○ weakness
- ○ fainting
- ○ **NONE**
- ○ poor balance
- ○ numbness
- ○ tingling
- ○ seizures
- ○ tremors
- ○ memory loss
- ○ difficulty with concentration
- ○ disturbances in coordination
- ○ falling down
- ○ visual disturbances
- ○ sensation of room spinning
- ○ excessive daytime sleeping

Psychiatric

- ○ thoughts of suicide
- ○ thoughts of violence
- ○ **NONE**
- ○ anxiety
- ○ depression
- ○ sense of great danger
- ○ mental problems
- ○ frightening visions or sounds

Endocrine

- ○ heat intolerance
- ○ weight change
- ○ **NONE**
- ○ cold intolerance
- ○ excessive thirst
- ○ excessive hunger
- ○ excessive urination

Heme/Lymphatic

- ○ skin discoloration
- ○ **NONE**
- ○ bleeding
- ○ fevers
- ○ enlarged lymph nodes
- ○ abnormal bruising

Allergic/Immunologic

- ○ seasonal allergies
- ○ **NONE**
- ○ hives or rash
- ○ persistent infections
- ○ HIV exposure

This form will be electronically scanned. To ensure that your feedback is properly recorded, make sure you have followed the marking instructions on the other side of this form.

Thank you for taking the time to complete this questionnaire!