Patient Name:_____

FOR WHAT REASON DID YOU MAKE THIS APPOINTMENT?_____

_____

HISTORY OF <u>PAST</u> ILLNESSES

(Please circle all that apply to you)

Cardiovascular—Stroke, High Blood Pressure, Heart Attack, Angina, Congenital Heart
Respiratory—Pneumonia, Emphysema, Chronic Bronchitis, Asthma, other Lung Disease
Endocrine—Diabetes, Thyroid Disease, Goiter,
Gastrointestinal—Stomach Ulcers, Hepatitis, Jaundice, Gallbladder Disease, Colitis
Genitourinary—Kidney Stones, Gout, Frequent Bladder infections, Sexually Transmitted Disease
Neurological—Headaches, Migraine Headaches, Seizures (epilepsy), Other Neurological disorder
HEENT—Glaucoma, Eye Problems, Allergies, Eczema
Behavioral—Alcoholism, Drug Abuse, IV Drug Abuse, Depression, Anxiety, other mental illness
Other—Cancer, Phlebitis, Bleeding Tendancy, Arthritis, _____

_____

HISTORY OF <u>HOSPITALIZATIONS AND SURGERIES</u>

(Please indicate specific surgery and approximate year)

<u>FAMILY HISTORY</u>: Please circle all that apply to your family members (indicate which family member: F=Father, M=Mother, GF=Grandfather, GM=Grandmother, S=Son, D=Daughter, SIB=sibling

Cardiovascular—Stroke, High Blood Pressure, Heart Attack, Angina, Other Heart Disorder
Respiratory—Pneumonia, Emphysema, Chronic Bronchitis, Asthma, Other lung Disease
Endocrine—Diabetes, Thyroid Disease, Goiter
Gastrointestinal—Ulcers, Hepatitis, Jaundice, Gallbladder Disease, Colitis, colon cancer, polyps
Genitourinary—Kidney stones, Kidney Disease, Gout, Frequent Bladder Infections
Neurological—Headaches, Migraine Headaches, Seizures (Epilepsy), Other Neurological Disorder
HEENT—Glaucoma, Eye Problems, Allergies, Eczema
Behavioral—Alcoholism, Drug Abuse, IV Drug Abuse, Depression, Anxiety, other mental illness
Other—Cancer, Phlebitis, Bleeding Tendency, Arthritis, _____

List of Present <u>Medications</u>

(Please list all **prescription, non-prescription**, **supplements** etc. with strength and dosing)

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

(Please List all **ALLERGIES**: Including Medication Allergies and your reaction to them)
_____ _____
_____ _____

PERSONAL HABITS
Tobacco: {}Cigarettes {}Pipe {}Chew {}None
Packs Per Day:_____ How Long have you been using Tobacco?_____
Alcohol: Do you Drink{}Regularly {}Socially {}Rarely {}Never _____Drinks Per week
Recreational Drugs: {}Yes {}No
Coffee: {}Regular {}Decaffeinated {}None ____Cups per day
Diet: {}Unrestricted(eat anything) {}Health Conscious (Eat mostly healthy)
{}Healthy (Strictly healthy foods)
Is your daily CALCIUM intake at least 1000 mg per day? [ ] Yes [ ] No
Exercise: {}None {}Type:_____
Durations of Activity_____ Times per week_____
Seatbelt use: {}Yes {}No

IMMUNIZATIONS
(Please check those you have had. Note most recent year received)
____Pneumonia (Pneumo-VAX) ____Tetanus, Diphtheria _____Influenza ____Hepatitis A or B
____Other:

DO YOU CURRENTLY HAVE (please circle all that apply):
- Eye Pain, Glaucoma, Blurred Vision
- Difficulty Hearing, Ringing in Ears, Earache
- Nasal Congestion, Nosebleeds, Postnasal Drainage, Sore Throat, Hoarseness, Trouble swallowing
- Fainting or Black outs, Dizziness, Seizures, Paralysis, Numbness/Tingling in Arms or Legs, Headaches

- Chronic Cough, Wheezing, Shortness of Breath, Difficulty Breathing
- Chest Pain or Chest Tightness, Irregular Heart Beat, Nighttime Awakenings Short of Breath
- Difficulty Breathing while on your Back, Pain in Calves while Walking

- Indigestion/Heartburn, Stomach Pain/Cramps, Diarrhea, Constipation
- Nausea, Vomiting, Vomiting of Blood, Blood in Stool, Black Tarry Stools, Change in Bowel Movements, Change in Stool

- Frequent Urination, Burning with Urination, Excessive Urination, Blood in Urine, Erectile Dysfunction
- Dribbling Urine, Urgency to Urinate, Incontinence (accidents), Genital Discharge

- Excessive Weight Gain, Weight Loss, Skin/Hair Changes or Rashes, Hives, Fatigue
- Excessive Thirst, Excessive Hunger, Excessive Urination
- Fever, Chills, Sweats, Swollen Lymph Nodes, Easy Bruising

- Joint or Muscle Pain, Joint Stiffness, Joint Swelling, Osteoporosis
- Neck Pain, Low Back Pain, Arm Pain, Leg Pain or cramps

- Depression, Anxiety, Unusual Stress
- Insomnia, Snoring, Pauses in Breathing
- Suicide Attempt, Childhood Abuse, Relationship Abuse

Patient Name:_____ **Date**: _____