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**Last Name**                                      **Middle Name**                                      **First Name**                                      **Today's Date**

**What is the reason for your visit today?** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**What symptoms are you having now?**  
 \_\_\_\_\_  
 \_\_\_\_\_

**List the Doctor that referred you and any other Doctor that you have seen in the last 12 months**

| <b>Doctors Name</b> | <b>Address</b> | <b>City/State/Zip</b> | <b>Phone/Fax</b> |
|---------------------|----------------|-----------------------|------------------|
|                     |                |                       |                  |
|                     |                |                       |                  |
|                     |                |                       |                  |
|                     |                |                       |                  |
|                     |                |                       |                  |

**Allergies (Please include drugs that cause indigestion or do not agree with you)**

**I have NO allergies:** \_\_\_\_\_  
**Latex Allergy?** \_\_\_\_\_YES                      \_\_\_\_\_NO  
 1. \_\_\_\_\_  
 2. \_\_\_\_\_  
 3. \_\_\_\_\_  
 4. \_\_\_\_\_  
 5. \_\_\_\_\_

**Vaccines:**

- |                             |                    |                   |
|-----------------------------|--------------------|-------------------|
| <b>1. Pneumonia</b>         | <b>Month</b> _____ | <b>Year</b> _____ |
| <b>2. Flu</b>               | <b>Month</b> _____ | <b>Year</b> _____ |
| <b>3. Zoster (Shingles)</b> | <b>Month</b> _____ | <b>Year</b> _____ |
| <b>4. Hepatitis</b>         | <b>Month</b> _____ | <b>Year</b> _____ |
| <b>5. Tetanus</b>           | <b>Month</b> _____ | <b>Year</b> _____ |

**Nutrition:**

**What is your usual weight?** \_\_\_\_\_ **Lbs.**                      **Has your weight changed?** \_\_\_\_\_ **Lbs.**  
**Gained** \_\_\_\_\_ **Lbs. or Lost** \_\_\_\_\_ **Lbs. in** \_\_\_\_\_ **Months/Years**

**Social History:**

Have you ever smoked cigarettes? Yes \_\_\_\_\_ No \_\_\_\_\_ Average # of packs per day \_\_\_\_\_  
How many years? \_\_\_\_\_ Year Quit \_\_\_\_\_  
Do you currently use tobacco? Yes \_\_\_\_\_ No \_\_\_\_\_  
Do you consume alcohol? Yes \_\_\_\_\_ No \_\_\_\_\_ Average amount per day \_\_\_\_\_  
Do you use recreational/street drugs? Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, what type? \_\_\_\_\_

**Demographics:**

Sex: \_\_\_\_\_ Male \_\_\_\_\_ Female  
Ethnicity: \_\_\_\_\_ Hispanic or Latino \_\_\_\_\_ Not Hispanic or Latino  
Race: \_\_\_\_\_ American Indian or Alaska Native  
\_\_\_\_\_ Asian  
\_\_\_\_\_ Black or African American  
\_\_\_\_\_ Native Hawaiian or Other Pacific Islander  
\_\_\_\_\_ White  
\_\_\_\_\_ Other

**FOR WOMEN:**

How old were you when your menstrual cycle began? \_\_\_\_\_  
What age at Menopause? \_\_\_\_\_  
Date of last menstrual cycle: \_\_\_\_\_  
Past Pregnancy? \_\_\_\_\_ Yes \_\_\_\_\_ No How many children? \_\_\_\_\_  
Is there a possibility you may be pregnant? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Have you taken birth control pills? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If yes, at what age did you start \_\_\_\_\_ stop \_\_\_\_\_  
Have you ever taken hormone replacement? \_\_\_\_\_ Yes \_\_\_\_\_ No How long? \_\_\_\_\_

**OTHER PAST ILLNESSES:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**LIVING WILL**

Do you have a Living Will? \_\_\_\_\_ Yes \_\_\_\_\_ No  
If no, do you want information? \_\_\_\_\_ Yes \_\_\_\_\_ No  
Who is your healthcare surrogate? \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone #: \_\_\_\_\_

## MEDICATION SHEET

Pharmacy(ies)

Name

Address

Telephone/Fax #

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Medications:

Name

Dose

Times per Day

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

6. \_\_\_\_\_

7. \_\_\_\_\_

8. \_\_\_\_\_

9. \_\_\_\_\_

10. \_\_\_\_\_

11. \_\_\_\_\_

12. \_\_\_\_\_

13. \_\_\_\_\_

14. \_\_\_\_\_

15. \_\_\_\_\_

16. \_\_\_\_\_

17. \_\_\_\_\_

18. \_\_\_\_\_

19. \_\_\_\_\_

20. \_\_\_\_\_

21. \_\_\_\_\_

22. \_\_\_\_\_

23. \_\_\_\_\_

24. \_\_\_\_\_

25. \_\_\_\_\_

**Family History of Cancer:**

**Relationship:** \_\_\_\_\_

**Type:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Type:** \_\_\_\_\_

**Relationship:** \_\_\_\_\_

**Type:** \_\_\_\_\_

**Hematologic/Lymphatic/Cancer: (check all that apply)**

- Anemia
- Bleeding, Clotting or bruising tendency
- Sickle Cell trait or disease
- Swelling/warmth/tenderness of veins/Phlebitis
- Lumps or swollen glands in neck
- Leukemia
- Blood Transfusion     Yes     No    Year(s): \_\_\_\_\_
- Cancer: Type \_\_\_\_\_  
Year \_\_\_\_\_

**Surgery / Anesthesia / Screening:**

**Last Mammogram:** \_\_\_\_\_

**Last PSA:** \_\_\_\_\_

**Last Colonoscopy:** \_\_\_\_\_

**Problems with Anesthesia:**     Yes     No

**Operations:**

| Type  | Year  |
|-------|-------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

## CURRENT/PAST MEDICAL HISTORY (Check ALL that apply)

|   |   |   |
|---|---|---|
| <b>CONSTITUTIONAL</b><br><input type="checkbox"/> Good health lately<br><input type="checkbox"/> Unusual fatigue/weakness<br><br><b>EYES:</b><br><input type="checkbox"/> Glaucoma<br><input type="checkbox"/> Wear Glasses/Contact lenses<br><input type="checkbox"/> Cataracts<br><input type="checkbox"/> Blurred Vision<br><input type="checkbox"/> Double Vision<br><br><b>ENT</b><br><input type="checkbox"/> Hard of hearing or deaf<br><input type="checkbox"/> Ear infections<br><input type="checkbox"/> Ringing in Ears<br><br><input type="checkbox"/> Chronic sinus Problems/Runny Nose<br><b>CHANGES/DIFFICULTY IN:</b><br><input type="checkbox"/> Taste<br><input type="checkbox"/> Smell<br><input type="checkbox"/> Voice<br><br><b>CARDIOVASCULAR:</b><br><input type="checkbox"/> Chest pain/Angina Pectoris<br><input type="checkbox"/> Palpitations<br><input type="checkbox"/> Heart murmur<br><input type="checkbox"/> High Blood Pressure<br><input type="checkbox"/> Heart attack<br><input type="checkbox"/> Congestive heart failure<br><input type="checkbox"/> High Cholesterol/Triglycerides<br><br><b>SKIN/BREAST:</b><br><input type="checkbox"/> Rashes or itching<br><input type="checkbox"/> Change in skin color or moles<br><input type="checkbox"/> Varicose veins<br><input type="checkbox"/> Breast pain/lump<br><input type="checkbox"/> Breast discharge or rash<br><input type="checkbox"/> Skin Cancer | <b>RESPIRATORY</b><br><input type="checkbox"/> Chronic or Frequent Cough<br><input type="checkbox"/> Bloody Sputum<br><input type="checkbox"/> Shortness of Breath<br><input type="checkbox"/> Asthma/Recurrent Wheezing<br><input type="checkbox"/> Emphysema<br><input type="checkbox"/> Pneumonia<br><br><b>GENITOURINARY:</b><br><input type="checkbox"/> Kidney Disease/Stones<br><input type="checkbox"/> Kidney Failure<br><input type="checkbox"/> Burning or pain on urination<br><input type="checkbox"/> Blood in Urine<br><input type="checkbox"/> Men: Prostate problem<br><input type="checkbox"/> Women: Menstrual irregularity or abnormal bleeding<br><input type="checkbox"/> Pelvic Pain<br><br><b>NEUROLOGICAL:</b><br><input type="checkbox"/> Brain, spinal cord or nerve problems<br><input type="checkbox"/> Light-Headed, dizzy, fainting spells<br><input type="checkbox"/> Convulsions, seizures, spasms, epilepsy<br><input type="checkbox"/> Stroke/TIA or paralysis<br><input type="checkbox"/> Head injury<br><input type="checkbox"/> Numbness, tingling<br><input type="checkbox"/> Tremors<br><br><b>ENDOCRINE:</b><br><input type="checkbox"/> Glandular or hormone problem<br><input type="checkbox"/> Heat or cold intolerance<br><input type="checkbox"/> Excessive Skin Dryness<br><input type="checkbox"/> Excessive thirst or urination<br><input type="checkbox"/> Weight problem<br><input type="checkbox"/> Diabetes<br><input type="checkbox"/> Hypothyroidism/Goiter<br><input type="checkbox"/> Hyperthyroidism<br><br><b>PSYCHIATRIC:</b><br><input type="checkbox"/> Anxiety/Agitation<br><input type="checkbox"/> Depression<br><input type="checkbox"/> Crying for no reason<br><input type="checkbox"/> Insomnia<br><input type="checkbox"/> Alcoholism<br><input type="checkbox"/> Drug Problem (Now/Past) | <b>GASTROINTESTINAL:</b><br><input type="checkbox"/> Nausea<br><input type="checkbox"/> Vomiting<br><input type="checkbox"/> Heartburn<br><input type="checkbox"/> Indigestion/Dyspepsia<br><input type="checkbox"/> Stomach fluid refluxing into mouth<br><input type="checkbox"/> Peptic ulcers<br><input type="checkbox"/> Hiatal hernia<br><input type="checkbox"/> Trouble/Pain swallowing<br><input type="checkbox"/> Lump or sensation in throat<br><input type="checkbox"/> Food sticking<br><input type="checkbox"/> Upper abdominal pain<br><input type="checkbox"/> Bloating<br><input type="checkbox"/> Belching<br><input type="checkbox"/> Lower abdominal pain<br><br><input type="checkbox"/> Diarrhea<br><input type="checkbox"/> Constipation<br><input type="checkbox"/> Rectal bleeding<br><input type="checkbox"/> Black or tarry stools<br><input type="checkbox"/> Hidden blood in stool<br><input type="checkbox"/> Excessive rectal gas/flatus<br><input type="checkbox"/> Loss of stool/fecal accident<br><input type="checkbox"/> Anemia<br><input type="checkbox"/> Chronic aspirin use<br><input type="checkbox"/> Poor appetite<br><input type="checkbox"/> Pancreas problems<br><input type="checkbox"/> Hepatitis or in the past<br><input type="checkbox"/> Transfusion<br><input type="checkbox"/> Jaundice or liver problems<br><br><b>MUSCULOSCKELATAL:</b><br><input type="checkbox"/> Joint Pain/Arthritis<br><input type="checkbox"/> Weakness of Muscles or Joints<br><input type="checkbox"/> Back Pain<br><input type="checkbox"/> Gout<br><input type="checkbox"/> Osteoporosis<br><input type="checkbox"/> Neck/Back pain |
|---|---|---|

Describe your mood/spirit:

What's your biggest worry? \_\_\_\_\_

Other issues: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_