MEDICAL INFORMATION

Name: _________________________________ DOB:________________

Reason for today's visit:____

Past Medical History: **Have you ever had any of the following? Check box if "Yes."**

Heart
- ________ Hypertension
- ________ Hyperlipidemia
- ________ Heart Attack
- ________ Congestive Heart Failure
- ________ Heart Murmur
- ________ Heart Valve Disorder
- ________ Atrial Fibrillation
- ________ Peripheral Vascular Disease
- ________ Deep Venous Thrombosis
- ________ Aortic Aneurysm
- ________ Carotid Stenosis
- ________ IHSS/ Subaortic Stenosis
- ________ Marfan Syndrome
- ________ Erhes- Danlos Syndrome

Lungs
- ________ COPD
- ________ Asthma
- ________ Emphysema
- ________ Sleep Apnea
- ________ Pulmonary Embolism
- ________ Asbestos Exposure
- ________ Positive PPD
- ________ Tuberculosis
- ________ Lung Nodules
- ________ Sacoidosis
- ________ Cystic Fibrosis
- ________ Polio

Gastrointestinal
- ________ GERD/Reflux
- ________ Hiatal Hernia
- ________ Diverticulosis
- ________ Colon Polyps
- ________ Gastric/Peptic Ulcer
- ________ Hepatitis
- ________ Ulcerative Colitis
- ________ Crohns Disease
- ________ Irritable Bowel Syndrome
- ________ Fatty Liver Disease
- ________ C. Diff Diarrhea
- ________ Pancreatitis

Nervous System
- ________ Seizure/ Epilepsy
- ________ Stroke
- ________ Head Injury
- ________ Parkinsons
- ________ Migraines
- ________ Alzheimers/Dementia
- ________ Mental Retardation
- ________ Aneurysm
- ________ Hydrocephalus/Shunt
- ________ Peripheral Neuropathy
- ________ Multiple Sclerosis

Psychiatry
- ________ Anxiety
- ________ Depression
- ________ Bipolar Disorder
- ________ ADHD
- ________ ADD
- ________ Learning Disability
- ________ Speech Delay
- ________ Obsessive Compulsive
- ________ Schizophrenia

Endocrine
- ________ Diabetes
- ________ Hypothyroidism
- ________ Goiter
- ________ Osteoporosis
- ________ Osteopenia

Kidney/Bladder
- ________ Polycystic Kidney
- ________ Kidney Stones
- ________ Kidney Failure
- ________ Dialysis
- ________ Recurrent UTI
- ________ Incontinence/Overactive Bladder

Musculoskeletal
- ________ Rheumatoid Arthritis
- ________ Osteoarthritis
- ________ Degenerative /Herniated Disc
- ________ Systemic Lupus Erythmatosis
- ________ Fibromyalgia
- ________ Gout

Congenital
- ________ Congenital Heart defect
- ________ Down Syndrome
- ________ Turners Syndrome
- ________ Cleft lip/Cleft palate
- ________ Prematurity
- ________ Congenital Hearing Loss

Skin
- ________ Psoriasis
- ________ Eczema
- ________ Rosacea

Blood
- ________ Anemia
- ________ Blood Transfusion
- ________ Bleeding Disorder
- ________ Clotting Disorder
- ________ Thalassemia
- ________ Sickle Cell

Infections
- ________ HIV
- ________ Herpes Simplex Virus
- ________ Chlamydia
- ________ Gonorrhea
- ________ Syphillis
- ________ Genital Warts
- ________ HPV

Eyes
- ________ Cataracts
- ________ Glaucoma
- ________ Macular Degeneration
- ________ Retinal Detachment
- ________ Diabetic Retinopathy

Ears/Nose/Throat
- ________ TMJ
- ________ Menieres Disease
- ________ Allergic Rhinitis

Cancer

Please name type of CANCER you have had :_______________
____

Female problems
- ________ Ovarian Cyst
- ________ Endometriosis
- ________ Uterine Fibroids
- ________ Abnormal PAP smear
- ________ Polycystic Ovarian Syndrome
- ________ Breast Mass
- ________ Miscarriage/Abortion
- ________ HPV

Male problems
- ________ BPH- Prostate Problems
- ________ PSA elevation
- ________ Erectile Dysfunction
- ________ Testicular Mass
- ________ Low Testosterone

Name: _________________________________ DOB:________________

Surgeries: Have you had any surgeries ? Check box if "yes" and write date of surgery .

________ Hernia/ what type?
________ Appendix
________ Gall bladder
________ Gastric Bypass
________ Ear Tubes
________ Tonsils
________ Adenoids
________ Sinus Surgery
________ Splenectomy
________ Cataracts
________ Laser eye Surgery
________ LASIK

________ Colonoscopy
________ EGD
________ Joint Replacement?/ what joint?_________
________ Coronary Artery Bypass/ Open Heart Surgery
________ Heart Valve Replacement/ what valve?________
________ Heart Catheterization
________ Heart Stent Placement
________ Heart Angioplasty
________ Carotid Surgery
________ Aneurysm repair
________ Greenfield filter

Female

________ Tubal Ligation
________ Hysterectomy/ovaries removed?
________ Colposcopy
________ LEEP/cervical surgery
________ D&C
________ Endometrial Ablation
________ Breast

Male

________ Vascectomy
________ TURP

Other surgery ______________________________________

Medications:

Medication Name	Dosage (mg)	# Pills taken	How many times per day

Allergies:

Medication/Other	Reaction

Social History:

Alcohol Use: __Never __Former __Current, Amount ____________
Tobacco Use: __Never __Former __Current, Amount ____________
Illegal Drug Use: __Never __Former __Current, Amount ____________
Type of Drugs used _______________________
Caffeine Use: __Never __Former __Current, Amount_____________

Marital Status ? _______________________________________
What is your highest level of education?_______________________
What is your occupation?______________________________

Have you ever been exposed to any hazardous materials? (Lead, Asbestos, etc) YES or NO
If YES, what material were you exposed to and when?________________________________

Are you at increased risk of infection? (TB, Hepatitis, Sexually Transmitted Diseases, etc)
YES or NO If YES, why?_________________________________

Do you wear your seat belt riding or driving a car? YES or NO

Do you have a routine exercise plan? YES or NO
How many times per week do you exercise?________________

Have you ever or do you currently serve in the military? YES or NO
If YES, what branch of military?_________________________

Is there any history of domestic violence (physical or verbal)? YES or NO
If YES, by whom?_______________

Do you have a Living Will/POA for Health Care ? YES or NO. Please provide a copy for your chart or you may request one from our office.

Name: ________________________________ DOB:_______________

Family History : ** Maternal = Mother's Family , **Paternal = Father's Family

	Mother	Father	Brother	Sister	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Children
Heart Disease									
High Blood pressure									
Diabetes									
Thyroid									
Cancer(type)									
Kidney									
Stroke									
Osteoporosis									
Mental Illness									

Please indicate by circling if you are experiencing any of the following symptoms at this time:

Fever / chills
Eye pain / vision changes
Headache / head injury
Chest pain
Irregular heart beats
Shortness of breath
Wheezing

Nausea/ vomiting/ diarrhea/ constipation
Abdominal pain
Blood in stool
Blood in urine
Burning with urination
Seizures / tremors
Anxiety / depression

Seasonal allergies
Rash
Change to skin lesion

Please indicate the last time you have had a:

Dental Ex _____________
Vision Ex _____________
Flu vaccin _____________
Pneumoni _____________
Tetanus va _____________
Heapatitis _____________
TB test _____________

<u>For WOMEN ONLY :</u>

Is there any chance of pregnancy today ? YES or NO

Age at onset of menstrual period? ___________ Date of last menstrual period? __________

Do you do regular self brest exams ? YES or NO

Do you use birth control ? YES or NO What type ? ________________

Number of pregnancies _________ Number of live births_________
Number of abortions ___________ Number of miscarriages________

Please indicate the year of your last:

Breast Exam ___________
Mammogram ___________
PAP smear _____________
HPV test _____________

<u>For MEN ONLY:</u>

Please indicate the year of your last :

Rectal/ Prostate exam __________
PSA _____________

PLEASE PROVIDE OUR OFFICE WITH A COPY OF YOUR IMMUNIZATIONS