

Name: _____ DOB: _____ Date: _____
Age: _____

Referring Physician: _____ Primary Care Physician: _____

Chief Complaint: _____

Past Medical History

Past Surgical History

Please list allergies of any kind, and include reactions: _____

Present Medications (Please include all prescription and non-prescription medications.)

Name	Dose	Name	Dose
1. _____	_____	6. _____	_____
2. _____	_____	7. _____	_____
3. _____	_____	8. _____	_____
4. _____	_____	9. _____	_____
5. _____	_____	10. _____	_____

Obstetrical History # of Pregnancies _____ # of Children: _____ Age at first live birth: _____
Age of menarche: _____ Age of menopause: _____

Social History/Habits Tobacco: Y / N _____ Type _____ Times per day _____
Exercise: Y/N _____ Times per wk _____ Caffeine: _____
Alcohol: Y/N _____ Times per wk _____ Street Drugs: Y/N _____

FAMILY HISTORY:

If Living

If Deceased

Relationship	Age	Health			Age at Death	Cause
Father		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
Mother		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
Brother/Sisters		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
M / F		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
M / F		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
M / F		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
M / F		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		
M / F		<input type="checkbox"/> Good	<input type="checkbox"/> Fair	<input type="checkbox"/> Poor		

Check if any blood relatives (mother, father, brother, sister, aunt, uncle, grandfather, grandmother) have had any of the following:

	YES		NO			YES		NO	
	YES	NO	YES	NO		YES	NO		
Stroke					Epilepsy				
Cancer					Emphysema				
High Blood Pressure					Bleeding Tendency				
Tuberculosis					Heart Attack				
Diabetes					Kidney Disease				
Leukemia					Arthritis				



Adult History Questionnaire

Name: _____ DOB: _____

Please check indicating if you have or have had problems with any of the following and describe in the space provided.

GENERAL HEALTH	YES	NO	COMMENTS
Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chills	<input type="checkbox"/>	<input type="checkbox"/>	_____
Fatigue or tiredness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Unexplained weight gain or loss	<input type="checkbox"/>	<input type="checkbox"/>	_____

EYES	YES	NO	COMMENTS
Disease/Injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Double Vision	<input type="checkbox"/>	<input type="checkbox"/>	_____
Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	_____

EARS/NOSE/MOUTH/THROAT	YES	NO	COMMENTS
Hearing Loss	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ringing in the Ears	<input type="checkbox"/>	<input type="checkbox"/>	_____
Earaches/Drainage	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chronic Sinus Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mouth Sores	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sore Throat	<input type="checkbox"/>	<input type="checkbox"/>	_____
Voice Changes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swollen Neck Glands	<input type="checkbox"/>	<input type="checkbox"/>	_____

CARDIOVASCULAR	YES	NO	COMMENTS
Heart Trouble	<input type="checkbox"/>	<input type="checkbox"/>	_____
Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rheumatic Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____
Irregular or fast heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Swelling of Feet/Hands	<input type="checkbox"/>	<input type="checkbox"/>	_____

RESPIRATORY	YES	NO	COMMENTS
Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coughing	<input type="checkbox"/>	<input type="checkbox"/>	_____
Spitting up Blood	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma/Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	_____

GASTROINTESTINAL	YES	NO	COMMENTS
Change in Bowel Movements	<input type="checkbox"/>	<input type="checkbox"/>	_____
Nausea/Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	_____
Rectal Bleeding/Blood in Stool	<input type="checkbox"/>	<input type="checkbox"/>	_____
Abdominal Pain/Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	_____
Peptic or Stomach Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

GENITOURINARY	YES	NO	COMMENTS
Frequent Urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Burning/Painful Urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood in Urine	<input type="checkbox"/>	<input type="checkbox"/>	_____
Incontinence or Dribbling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexual Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	_____
Male – Testicle Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Female – Irregular Periods	<input type="checkbox"/>	<input type="checkbox"/>	_____
Female - Planning pregnancy	<input type="checkbox"/>	<input type="checkbox"/>	_____

	YES	NO	COMMENTS
Females - Menopause	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sexually Transmitted Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____

MUSCULOSKELETAL	YES	NO	COMMENTS
Joint Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Muscle Weakness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Joint Stiffness/Cramping	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gout	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____

SKIN/BREAST	YES	NO	COMMENTS
Rash or Itching	<input type="checkbox"/>	<input type="checkbox"/>	_____
Change in Skin Color	<input type="checkbox"/>	<input type="checkbox"/>	_____
Change in Hair/Nail Color	<input type="checkbox"/>	<input type="checkbox"/>	_____
Varicose Veins	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Pain	<input type="checkbox"/>	<input type="checkbox"/>	_____
Female – Breast Discharge	<input type="checkbox"/>	<input type="checkbox"/>	_____

NEUROLOGICAL	YES	NO	COMMENTS
Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Frequent Headaches	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lightheadedness/Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Numbness/Tingling	<input type="checkbox"/>	<input type="checkbox"/>	_____
Tremors	<input type="checkbox"/>	<input type="checkbox"/>	_____
Head injury	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blackout/Loss of Consciousness	<input type="checkbox"/>	<input type="checkbox"/>	_____

PSYCHIATRIC	YES	NO	COMMENTS
Nervousness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____
Insomnia	<input type="checkbox"/>	<input type="checkbox"/>	_____

ENDOCRINE	YES	NO	COMMENTS
Hormone Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive Thirst	<input type="checkbox"/>	<input type="checkbox"/>	_____
Excessive Urination	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heat/Cold Intolerance	<input type="checkbox"/>	<input type="checkbox"/>	_____
Dry Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____

HEMATOLOGY/LYMPHATIC	YES	NO	COMMENTS
Slow to Heal After Cuts	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding or Bruising Tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	_____
Past Transfusions	<input type="checkbox"/>	<input type="checkbox"/>	_____
Enlarged Glands	<input type="checkbox"/>	<input type="checkbox"/>	_____
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	_____

ALLERGIC/IMMUNOLOGIC	YES	NO	COMMENTS
Food Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Environmental Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____
Latex Allergies	<input type="checkbox"/>	<input type="checkbox"/>	_____

Reviewed by: _____ Initials / Date _____ Initials / Date _____