

Name _____ Age _____ Date _____

Medications _____

Allergies _____ Birth control method _____

Date of last physical exam _____

Hospitalizations or Surgeries:

Date:	Surgery or reason for hospitalization:

Family history: Please indicate whether immediate relatives (parents, children, grandparents, aunts/uncles) have had any of the following:

Breast cancer _____	High cholesterol _____	Alzheimer's disease _____
Prostate cancer _____	High blood pressure _____	Depression _____
Testicular cancer _____	Heart attack _____	Anxiety _____
Skin cancer _____	Aneurysms _____	Thyroid disease _____
Colon cancer _____	Stroke _____	Alcoholism _____
Other cancer _____	Osteoporosis _____	Diabetes _____

Social History: I live with _____ Marital status _____ Occupation _____

Do you smoke? _____ Packs per day _____ Do you drink? _____ Drinks per week _____ Do you use drugs now or in the past? _____

Health problems or concerns. Mark "C" for current problems and "X" for past problems.

<p>General</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Blood clot in lungs or leg</p> <p><input type="checkbox"/> Eating disorder</p> <p><input type="checkbox"/> Unusual fatigue</p> <p><input type="checkbox"/> Abnormal thirst</p> <p><input type="checkbox"/> Sleeping problems</p> <p><input type="checkbox"/> Skin trouble</p> <p><input type="checkbox"/> Back pain</p> <p>Neurological</p> <p><input type="checkbox"/> Frequent headaches</p> <p><input type="checkbox"/> Fainting spells</p> <p><input type="checkbox"/> Seizures</p> <p><input type="checkbox"/> Dizzy spells</p> <p><input type="checkbox"/> Depression or anxiety</p> <p>Neck</p> <p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Lump</p> <p><input type="checkbox"/> Pain or stiffness</p>	<p>Heart</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Heart murmur</p> <p><input type="checkbox"/> Heart attack/problems</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Shortness of breath</p> <p><input type="checkbox"/> Night sweats</p> <p><input type="checkbox"/> Chest pain or pressure</p> <p><input type="checkbox"/> Palpitation or fluttering</p> <p><input type="checkbox"/> Swollen ankles</p> <p>Lungs</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Chronic cough</p> <p>Breast</p> <p><input type="checkbox"/> Lump</p> <p><input type="checkbox"/> Discharge</p> <p><input type="checkbox"/> Pain</p>	<p>Intestinal</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Bowel problems</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Gallbladder problems</p> <p><input type="checkbox"/> Loss of appetite</p> <p><input type="checkbox"/> Nausea or vomiting</p> <p><input type="checkbox"/> Vomiting of blood</p> <p><input type="checkbox"/> Pain in abdomen</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Blood in stools</p> <p><input type="checkbox"/> Black, tarry stools</p> <p>Genital</p> <p><input type="checkbox"/> Testicular pain</p> <p><input type="checkbox"/> Urethral Discharge</p> <p><input type="checkbox"/> Chlamydia of gonorrhea</p> <p><input type="checkbox"/> Herpes</p> <p><input type="checkbox"/> Difficulty in getting / maintaining erection</p> <p><input type="checkbox"/> Painful erection</p> <p><input type="checkbox"/> Premature ejaculation</p> <p><input type="checkbox"/> Sexual concerns</p>	<p>Urinary</p> <p><input type="checkbox"/> Kidney infections/stones</p> <p><input type="checkbox"/> Bladder infections</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Pain with urination</p> <p><input type="checkbox"/> Urine leakage</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Difficulty starting/stopping stream</p> <p>Extremities</p> <p><input type="checkbox"/> Arthritis, joint pain</p> <p><input type="checkbox"/> Varicose veins</p> <p><input type="checkbox"/> Broken bones</p> <p>Endocrine</p> <p><input type="checkbox"/> Thyroid disease</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Osteoporosis</p>
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Any other illnesses, symptoms, special problems or concerns today that are not listed above? _____

Thank you for taking the time to complete this questionnaire. It will allow us to more completely address your needs and concerns.

