

Patient's Name:

Date:

Please list the prescription medications you take.

Please list any over-the-counter meds you take including vitamins and supplements.

YES NO **Do you have any allergies or sensitivities to any medications?** If so, which ones and what was the reaction?

Past Medical History

YES NO Have you been told you have high blood pressure?
YES NO Do you have heart disease (have you ever had angina, or a heart attack)?
YES NO Have you been told you have high cholesterol?
YES NO Have you been told you have diabetes or high blood sugar?
YES NO Have you ever had kidney disease?
YES NO Have you ever been diagnosed with cancer? If yes, what type and when?

YES NO Have you ever been injured? Please explain.

YES NO Have you ever received a blood transfusion? If yes, when?
YES NO Have you had any surgeries? If so, when and for what?

Please describe any hospitalizations you have had.

YES NO Have you been diagnosed with AIDS (HIV disease)?
YES NO Do you know of any possible exposures to HIV (the AIDS virus)?
YES NO Have you ever had problems with your liver? If so, what?
YES NO Have you ever had any possible exposure to hepatitis?
YES NO Have you ever had problems with your mood such as depression or anxiety?
YES NO Have you had any lung disease such as asthma, emphysema, or tuberculosis?
YES NO Have you ever been diagnosed with ulcers, colitis, polyps, or Crohn's disease?
YES NO Have you ever had a stroke or a seizure?
YES NO Have you ever had thyroid problems or an abnormal thyroid test?
YES NO Do you have a history of cataracts or glaucoma?
YES NO Do you have arthritis?
YES NO Have you ever been told you have osteoporosis?
YES NO Have you ever had a head injury with loss of consciousness and/or vomiting?
YES NO Have you had episodes of passing out? Please explain.
YES NO Have you ever been the victim of physical/emotional/sexual abuse or assault?
YES NO Have you had any sexually transmitted diseases? When and what type?
YES NO Have you ever been exposed to any chemicals, toxins, poisons or fumes?

Habits

YES NO Have you ever smoked cigarettes, pipe, or cigars or chewed tobacco?
How much and for how long? #_____packs/day x #_____years. If you have quit, when?
If you smoke, please rate your interest in quitting from 1 (not at all) to 10 (very)
How much alcohol do you drink? #_____daily; #_____ weekly; #_____ monthly
Please indicate (circle) if you have used any of the following substances:
Cocaine Speed Marijuana Heroin PCP LSD Glue/Paint mushrooms Ecstasy
Any other drugs with needles Others When?_____ How long?_____
How much caffeinated beverages (coffee, colas, tea) do you drink daily?

Social History

What is your marital status?
Single Married Divorced Separated Widowed
YES NO If you are married, are you experiencing any marital problems?
Who lives at home with you?
YES NO Do you have supportive friends or family in the area?
How many years of education do you have?
YES NO Are you currently employed? If yes, in what field?
YES NO Are you entirely satisfied with your sex life?
YES NO Do you have questions regarding sex that you wish to discuss with the doctor?
YES NO If you're sexually active, do you (or your partner) use birth control? What form?
YES NO If the answer above was not condoms, do you also use condoms?

Family History

In your family, is there any history of the following diseases (circle & specify below)?:
Seizures Kidney disease Cancer (what type?)
Alcoholism Heart disease (heart attack/angina) High blood pressure
Asthma Drug Abuse Diabetes
Depression Stroke Tuberculosis
Headaches Thyroid disease Other _____

Relative	Disease (if any)	Still Living? (Y/N)	Age Now or at Death
Father			
Mother			
Bro/Sis			
Bro/Sis			
Bro/Sis			
Bro/Sis			
Other			

Activities of Daily Living

- YES NO Are you able to do your own bathing and dressing?
YES NO Do you use a walker, cane, wheelchair, hospital bed or oxygen?
YES NO Do you require the assistance of another person to walk about?
YES NO Have you experienced any falls?
YES NO Do you have any problems eating (such as binging or purging, or compulsive overeating)?

Review of Current Symptoms

- YES NO Have you recently had any fevers, chills or night sweats?
YES NO Have you an increase or decrease in your appetite?
YES NO Have you gained or lost 10 pounds or more in the past three months?
YES NO Do you still enjoy the things that used to be enjoyable for you?
YES NO Have you ever experienced any chest pain?
YES NO Do you struggle with mood swings?
YES NO Have you experienced any change in your vision?
YES NO Have you experienced any change in your hearing?
YES NO Have you experienced any changes in bowel habits or blood in your stool?
YES NO Have you experienced any loss of control of bowel or bladder?
YES NO Do you have any difficulties with your sleep?
YES NO Have you experienced any difficulties with your sexual functioning (such as decreased interest, difficulty with arousal, problems with achieving or maintaining an erection, or ability to climax)?
YES NO Have you experienced a loss of energy?
YES NO Do you ever feel very tense or panicky?
YES NO Have you experienced more headaches than usual for you?

Wellness/Health Screening

- When was your last dental exam?
When was your last eye exam?
How often do you exercise?
Never Less than 1x/wk 1-2x/wk 3-4x/wk 5 or more x/wk
If you exercise, what do you do?
YES NO Do you eat three balanced meals a day?
When was your cholesterol last checked?
When was your last tetanus booster?
YES NO Have you ever been immunized against pneumonia?
When did you last have a test for blood in the stool (if you have had one)?
YES NO Have you ever had a colonoscopy or flexible sigmoidoscopy? If so, when?
(If you have to ask what it is, you haven't had one!)
- FOR MEN:
When did you last have your prostate examined (by rectal exam)?
When was your last PSA test (blood test for prostate cancer)?