

Patient Name:

Check any symptoms experienced in the past year.

General:

- Poor appetite
- Increased appetite
- Fever

EENT:

- Hearing loss
- Ringing/ roaring in ears
- Ear pain
- Vertigo ("room spinning")
- Nosebleeds
- Hoarseness of voice
- Double vision

Endocrine:

- Heat/ cold intolerance
- Weight gain/ loss
- Thin skin
- Oily skin/ acne
- Thinning/ brittle hair
- Neck mass
- Easily fatigued
- Exercise intolerance
- Loss of muscular strength
- Loss of muscular mass
- Poor sleep pattern
- Poor memory
- Trouble concentrating
- Decreased/ increased appetite
- Craving sweets
- Exercise intolerance

Genito-urinary:

- Loss of Libido
- Painful urination
- Frequent urination
- Mood Change:
- Depression:
- Anxiety:
- Weight Gain

Females:

- Pelvic pain
- Vaginal dryness
- Painful intercourse

- Flank pain
- Menstrual Irregularity
- Heavy periods
- Light /no periods
- Premenstrual Mood changes
- Premenstrual migraines:
- Other menstrual symptoms:
- Recent Changes in menstrual Periods:
- Hot Flashes:
- Increased facial hair
- Fluid retention
- Breast tenderness

Males

- Erectile Dysfunction:
- Nighttime urination:
- Weak urinary stream:
- Difficulty starting urination:
- Testicular shrinkage:
- Steroid use in the past
- Lump in the testicle

Gastro-intestinal:

- Abdominal pain
- Constipation
- Diarrhea
- Black stools
- Bloody stools
- Nausea
- Vomiting

Cardio-vascular

- Chest pain
- Shortness of breath
- Irregular heartbeat
- Rapid/slow heartbeat
- Ankle swelling
- Varicose veins
- Fainting

Neurological:

- Headache
- Change in vision
- Double vision
- Weakness

- Tingling
- Dizziness

Musculo-skeletal:

- Joint pain
- Joint swelling
- Location: _____

Pulmonary:

- Wheezing
- Cough
- Coughing blood
- Frequent respiratory infections

Skin

- Rash
- Itching
- Change in a mole(s)
- Sore that won't heal

Lymphatic-Hematologic:

- Easy bruisability
- Bleeding gums

Personal Medical History

Conditions diagnosed in the past or at present

- Diabetes:
- Hypoglycemia:
- High blood pressure
- High cholesterol
- Heart disease
- Angina
- Coronary artery disease
- Heart attack
- Congestive heart failure
- Peripheral vascular disease
- Blood clots
- Pulmonary embolism
- Emphysema (smokers lung)
- Chronic bronchitis
- Asthma
- Collapsed lung
- Pneumonia
- Other lung disease
Specify: _____
- T.I.A. (blackout spell)
- Stroke
- Cerebral vascular disease
- Seizure/epilepsy
- Head injury
- Multiple Sclerosis
- Other Neurologic disease:
Specify: _____
- Chronic/ recurrent sinusitis
- Respiratory allergies, hayfever
- Food allergies
- Contact allergies
- Any severe allergic reactions:
(to what:)_____
- Poor resistance to infections
- Immune suppression:
- HIV infection
- Any cancer: _____
- Radiation therapy
- Chemotherapy
- Hepatitis: (type: A/B/C/other)
- Herpes infection: (oral/ genital)
- Shingles
- Chronic recurrent fungal infections:
- Mononucleosis:(age)____
- Chronic fatigue syndrome

- Fibromyalgia
- Arthritis
- Rheumatoid arthritis:
- Lupus (SLE):
- Disk disease:(back/neck_____
- Ulcers: (age)_____
- Esophageal reflux:
- Gastrointestinal bleeding:(age)____
- Hemorrhoids:
- Gastrointestinal cancer:
(type)_____
- Diverticulitis
- Crohns disease
- Ulcerative colitis
- Hyperthyroidism
- Hypothyroidism
- Pituitary disease
- Adrenal disease
- Depression:(age at onset)_____
- Chronic anxiety:
(age at onset)_____

Females:

- Age at Menarche: _____
- Endometriosis
- Ovarian cysts
- Fibroids
- Irregular periods
- Fibrocystic breasts
- Pelvic pain
- Birth control pills
- IUD
- Birth control shots (Provera)
- Hysterectomy:
Total/Partial: Age: _____
- Pregnancy: #_____
- Problems with Pregnancy:
- Weight Gain after Pregnancy:
- Menstrual problems after pregnancy
- "Hormone" problems after pregnancy
- Menopause:(y/n)_____ Age:___

Males:

- Elevated PSA
- Cancer of Prostate
- Enlargement of Prostate
- Prostate infection (Prostatitis)

- Prostate surgery
- Testicular surgery/injury
- Kidney stone

Surgery:

- Coronary artery bypass
- Angioplasty/ stent
- Heart valve surgery
- Pacemaker:
- Appendectomy: (age)_____
- Tonsillectomy: (age)_____
- Gall bladder surgery: (age)_____
- Back surgery: _____
- Chest surgery: _____
- Abdominal surgery: _____
- Other: _____

Family History

Parents:

Mother: Living: (y/n)_____ Present age or age at death: _____ Cause of Death: _____

Diabetes Heart Attack (Age of first heart attack: _____) Hypertension High Cholesterol

Smoke cigarettes: (y/n)_____ If yes: heavy light

Drink alcohol: (y/n)_____ If yes: heavy light

History of: Breast Cancer Lung Cancer Colon Cancer Skin Cancer

Father: Living: (y/n)_____ Present age or age at death: _____ Cause of Death: _____

Diabetes Heart Attack (Age of first heart attack: _____) Hypertension High Cholesterol

Smoke cigarettes: (y/n)_____ If yes: heavy light

Drink alcohol: (y/n)_____ If yes: heavy light

History of: Breast Cancer Lung Cancer Colon Cancer Skin Cancer

Grand Parents:

Maternal Grandmother: Living: (y/n) Present age or age at death: _____ Cause of Death: _____

Diabetes Heart Attack (Age of first heart attack: _____) Hypertension High Cholesterol

Smoke cigarettes: (y/n)_____ If yes: heavy light

Drink alcohol: (y/n)_____ If yes: heavy light

History of: Breast Cancer Lung Cancer Colon Cancer Skin Cancer

Maternal Grandfather: Living: (y/n) Present age or age at death: _____ Cause of Death: _____

Diabetes Heart Attack (Age of first heart attack: _____) Hypertension High Cholesterol

Smoke cigarettes: (y/n)_____ If yes: heavy light

Drink alcohol: (y/n)_____ If yes: heavy light

History of: Breast Cancer Lung Cancer Colon Cancer Skin Cancer

Family History(continued)

Grand Parents:

Paternal Grandmother: Living: (y/n) Present age or age at death: _____ Cause of Death: _____

Diabetes Heart Attack (Age of first heart attack: _____) Hypertension High Cholesterol

Smoke cigarettes: (y/n)_____ If yes: heavy light

Drink alcohol: (y/n)_____ If yes: heavy light

History of: Breast Cancer Lung Cancer Colon Cancer Skin Cancer

Paternal Grandfather: Living: (y/n) Present age or age at death: _____ Cause of Death: _____

Diabetes Heart Attack (Age of first heart attack: _____) Hypertension High Cholesterol

Smoke cigarettes: (y/n)_____ If yes: heavy light

Drink alcohol: (y/n)_____ If yes: heavy light

History of: Breast Cancer Lung Cancer Colon Cancer Skin Cancer

Siblings:

Sister(s): Deceased: (#) _____ Age(s) at death: _____ Cause(s) of death: _____

Diabetes Heart Attack (Age of first heart attack: _____) Hypertension High Cholesterol

Smoke cigarettes: (y/n)_____ If yes: heavy light

Drink alcohol: (y/n)_____ If yes: heavy light

History of: Breast Cancer Lung Cancer Colon Cancer Skin Cancer

Brother(s): Deceased: (#) _____ Age(s) at death: _____ Cause(s) of death: _____

Diabetes Heart Attack (Age of first heart attack: _____) Hypertension High Cholesterol

Smoke cigarettes: (y/n)_____ If yes: heavy light

Drink alcohol: (y/n)_____ If yes: heavy light

History of: Breast Cancer Lung Cancer Colon Cancer Skin Cancer

Habits

Tobacco: (y/n)_____ if yes, how frequently: o daily, o _____times a week, o occasionally, o rarely.

How many packs_____

Since what age: _____; if no, in the past: (y/n)_____

If yes, how frequently: o daily, o _____times a week, o occasionally, o rarely.

How many packs _____ per day

And when did you quit: _____.

Alcohol: (y/n)_____ if yes, how frequently: o daily, o _____times a week, o occasionally, o rarely.

How many drinks_____ (1 drink 1 mixed drink 1 glass wine/1 beer)

Since what age: _____; if no, in the past: (y/n)_____

If yes, how frequently: o daily, o _____times a week, o occasionally, o rarely.

How many drinks _____ (1 drink 1 mixed drink 1 glass wine/1 beer)

When did you quit: _____.

Caffeine: (y/n)_____ if yes, how frequently: o daily, o _____times a week, o occasionally, o rarely.

How many cups_____

Since what age: _____; if no, in the past: (y/n)_____

If yes, how frequently: o daily, o _____times a week, o occasionally, o rarely.

How many cups

When did you quit: _____.

Preventive Medicine:

Regular Doctor: (name) _____

Annual Physical: Date: _____ Result: (Normal: y/n) _____

Lipogram: Date: _____ Result: (Normal: y/n) _____

Hemocult: Date: _____ Result: (Normal: y/n) _____

Colonoscopy: Date: _____ Result: (Normal: y/n) _____

Stresstest: Date: _____ Result: (Normal: y/n) _____

Chest x-ray: Date: _____ Result: (Normal: y/n) _____

Skin Survey: Date: _____ Result: (Normal: y/n) _____

Women:

PAPP Smear: Date: _____ Result: (Normal: y/n) _____

Breast Exam: Date: _____ Result: (Normal: y/n) _____

Mammogram: Date: _____ Result: (Normal: y/n) _____

Bone Density: Date: _____ Result: (Normal: y/n) _____

Men:

Rectal Exam: Date: _____ Result: (Normal: y/n) _____

PSA: Date: _____ Result: (Normal: y/n) _____

Prescription Medications:

Supplements:

Vitamin E: ____IU/day Vitamin C: ____mg/day Aspirin: ____mg/day Ca: ____mg/day

Multi-Vitamin: _____

Other: _____

Lifestyle:

Exercise: Frequency: _____ Consistency: regularly/episodic/occasional/sporadic/never

Time spent per session: _____

Percent of above time spent on: Aerobic: _____ Resistive: _____

Sports:

Hobbies:

Occupation:
