COMPREHENSIVE MEDICAL HISTORY

This important information is confidential. No one other than your healthcare provider will have access or knowledge of this information without your express written consent. Thank you very much for taking the time to fill out this lengthy form. Completion of this history allows us to provide you the most complete medical care possible. This form will be reviewed with you during your visit.

General:

Date of your last complete physical exam:	Date of your last Chest Xray:
Date of your last cholesterol Screening:	Date of your last Dental Exam:
Women:	**Men:**
Date of your last mammogram:	Date of last PSA:
Date of your last pap smear:	Date of last rectal/prostate exam:

Immunizations:

Measles-Mumps-Rubella (MMR):	Pneumonia:
Tetanus and Diptheria Toxoids(Td):	Hepatitis B:
Influenza:	

Past Medical History (Circle all that apply)

AIDS/HIV+	Chicken Pox	Measles	Rheumatic Fever	Blood or Plasma Transfusions
Cancer	Epilepsy	Mumps	Scarlet Fever	Cancer
Infectious Mononucleosis		Polio	Whooping Cough	

Hospital/Surgical History:

Illness or Operation and Date:

1)	2)
3)	4)
5)	6)

Allergies: (Please list any drug, food, contact or environmental substances to which you have had an allergic or bad reaction:

Medications: (Please list any prescription medications, over the counter medications, vitamins, herbs, or nutritional supplements that you are now taking. Please include the dosage amount and the times you take them.

1)	2)
3)	4)
5)	6)

Social History:

Occupation: Marital Status:

Do you exercise Regularly? YES NO What Type: How Often:

I have never smoked: YES NO I currently smoke: ____ packs a day I have smoked for ____ years

I formerly smoked but I stopped in: (list year) _____ Do you wear seatbelts: YES NO

Do you use other forms of tobacco: YES NO Do you use illicit drugs: YES NO Do you drink alcohol:

Do you have any risk factors for HIV infection: YES NO Have you ever been exposed to tuberculosis: YES NO

Have you had excessive exposure to the sun because of work or recreation: YES NO

Are you currently experiencing unusual stress: YES NO Explain:

Are there any environmental risks involved in your job or home environment: YES NO Explain:

Family History: (Please specify Relationship)

Anemia	Epilepsy	High Cholesterol	Asthma
Glaucoma	Kidney Disease	Obesity	Leukemia
Cancer	Depression	High Blood Pressure	Diabetes
Heart Disease	Alcohol Problems	Stroke	Lung Disease

Present Age of Death: Mother: Father: Sibling 1:

Sibling 2: Sibling 3:

Women Only: Menstrual Period Onset Regula YES NO Date last period began:

Age at menopause: Difficulty with periods: YES NO Specify:

Pregnancies: (Number of Children) Born Alive : Cesarean: Premature: Stillborn: Miscarriages:

Please check all conditions you currently have or had:

General Questions
Weight Loss
Weight Gain
Change in Sleep Patterns
Change in Activity Capacity

Neurologic and Psychiatric
Anxiety
Headaches
Depression
Meningitis
Paralysis
Seizure
Stroke
Tingling
Tremors
Memory Loss
Fainting Spells, Dizziness
Head Injuries
Blackouts
Change in Sensation on body
Localized Weakness or Numbness

Ears, Eyes, Nose & Throat
Hay fever
Glaucoma
Polyps
Allergy
Cataracts
Goiter
Hoarseness
Double Vision
Gum Problems
Eye Problems
Ear Infections
Glasses/Contacts
Hearing Loss
Ear discharge/Pain
Frequent Nosebleeds
Ringing in your ears
Sinus Infection
Swollen Glands

Cardiovascular:
Angina
Chest Pain
Leg Cramps
Murmurs
Ankle Swelling
Awakening at night short of breath & getting out of bed
Cardiac Catheterization
Cold hands or feet
Congenital Heart Defects
Dizziness when standing too quickly
Heart attacks
Heart Failure
High or Low Blood Pressure
Irregular Heart rate
Purple fingers or lips
Leg pain that resolves with rest
Heart Palpitations
Varicose Veins

Respiratory:
Pleurisy
Wheezing
Asthma
Breathlessness when lying flat
Prolonged Cough
Coughing up blood
Emphysema
Shortness of Breath
Tuberculosis
Pneumonia
Frequent Infections

Skin:
Abscess
Acne
Boils
Hives
Dandruff
Oily Skin
Rashes
Dry Skin
Psoriasis
Lumps
Jaundice
Athletes Foot
Excessive Body Odor
Excessive Sweating
Fungal Infections
Nail Problems
Moles-irregular
Moles-Change/new

Kidneys & Urinary Tract
Blood in Urine
Brown Urine
Dribbling after urinating
Painful Urination
Excessive Thirst
Involuntary urination/incontinence
Urinating frequently
Urine Hesitancy
Weak Flow
Frequent bladder infections
Kidney Disease
Kidney Stone

Endocrine:
Diabetes
Sickle Cell
Abnormal Body Hair
Changes in skin
Cold intolerance
Heat Intolerance
History of "borderline" diabetes
Increased hair loss
Rheumatism
Thyroid Disease

Male & Female:
Hernia
Sterility
Bloody Ejaculation
Inability to complete intercourse
Lump on testicle
Penile Discharge
Premature Ejaculation
Problems maintaining an erection
Prostate Disease
Sores on penis or warts
Testicular pain
Testicular swelling

Musculoskeletal:
Anemia
Back Pain
Arthritis
Bursitis
Gout
Joint Aches
Neck Pain
Tendonitis
Abnormal Blood Counts
Blood Clots in legs/lungs
Bone Marrow biopsy
Easy bleeding
Easy bruising
Joint swelling
Morning stiffness
Muscle aches

Gastrointestinal:
Diarrhea
Gallstones
Reflux
Vomiting
Ulcers
Heartburn
Hepatitis
Indigestion
Abdominal Pain
Anal fissures
Black tarry stool
Vomiting blood
Constipation
Nausea
Problems swallowing
Hiatal hernia
Intestinal obstruction
Liver disease
Hemorrhoids
Red blood after bowel movements

Females Only:
D&C
Hot flashes
Fibroids
Hernia
Abnormal bleeding
Bleeding after sex
Complications w/pregnancy
PMS
Endometriosis
Heavy bleeding on cycle
Discharge from breasts
Ovarian cysts
Pelvic inflammatory Disease
Postmenopausal symptoms
Vaginal discharge
Vaginal dryness
Vaginal warts