

Patient Name: _____

Family History: Do any of the following family members have heart, kidney, respiratory problems or cancer?

<u>Member</u>	<u>Alive</u>	<u>Deceased</u>	<u>Age</u>	<u>Health status or cause of death</u>
Mother	A	D	_____	_____
Father	A	D	_____	_____
Brother	A	D	_____	_____
Sister	A	D	_____	_____
_____	A	D	_____	_____

Review of Systems: Please circle any that apply to your current state of health.

Constitutional: Weight loss Weakness Fatigue Fever/Chills None

Eyes: Vision changes Double vision None

Ear/Nose/Mouth/Throat: Nasal drainage Sneezing Hoarseness Hearing loss

Ear pain: Ringing of ears Nose bleeds None

Neck: Masses tenderness None

Respiratory: Cough Wheezing Shortness of Breath Asthma None

Cardiovascular: Heart murmur Ankle swelling Nausea Chest pain

High blood pressure None

Chest (breasts): mass nipple discharge tenderness History of breast cancer None

Gastrointestinal: Diarrhea Constipation Urinary pain Blood in urine

blood in stools Vomiting Heart burn None

Genitourinary: Genital discharge Urinary frequency None

Lymphatic: (neck, axilla, groin, other): Lymph node changes Swelling None

Musculoskeletal: any pain in neck upper back lower back shoulder arm hip

high leg foot limp mass loss of muscle strength None

Skin: Rash lesions ulcers open wound drainage None

Neurologic: Seizure Stroke Paralysis Muscle weakness Unconsciousness Memory

changes None

Psychiatric: Anxiety Suicidal thoughts Depression Sleep Disturbance

agitation None

If you have circled any of the above, please explain below:

Please circle what studies you have had for this problem and brought with you to your appointment for physicians review.

RI, CT, Bone Scan, Plain X-Rays, Blood work, Histology slides (previous biopsy)

Attest that the above information is true and correct to the best of my knowledge.

Name of person filling out form: _____ Relation: _____

Patient Signature: _____ Date: _____

Patient Name: _____

Doctors you have seen for this problem: _____

Primary Care Physician: _____

Please take the time to fully and accurately fill out this form.

Printed Name: _____

History of present illness: mass (lump) _____ lesion _____ pain _____

Where at on your body: _____ Left Right

When was date of first symptom or signs of problem? _____

Severity of pain, rate on a scale of 1 to 10 (10 being the most painful) _____

Is the pain: sharp dull aching stabbing throbbing constant or sometimes

What activities cause the pain? _____

Past Medical History

Normal Childhood diseases: _____

Last Tetanus Vaccine: _____ Major Illnesses: _____

Have you ever had any problems with general anesthesia? NO YES

Describe _____

Surgeries	Dates	Complications

General: Weight _____ Height _____ Age _____

If female list date of last Pap: _____ Mammogram _____

Social History: What do you do for employment? _____ student _____

Tobacco Use: Yes No Prev. Smoker: Yes Year quit: _____ Smokeless user: No Yes

The US Surgeon General has said, "Smoking cessation [stopping smoking] represents the single most important step that smokers can take to enhance the length and quality of their lives."

Alcohol Use: No Yes How often: daily weekly monthly How many: _____

Unhealthy alcohol use covers a spectrum that is associated with varying degrees of risk to health. Categories representing unhealthy alcohol use include risky use, problem drinking, harmful use, and alcohol abuse, and the less common but more severe alcoholism and alcohol dependence. Risky use is defined as > 7 standard drinks per week or > 3 drinks per occasion for women and persons > 65 years of age; > 14 standard drinks per week or > 4 drinks per occasion for men ≤ 65 years of age.

Do you wear your seat belt? always sometimes never

Exercise: Daily Weekly Monthly Rarely Never What type of exercise? _____

Are you on a special diet? YES NO Describe _____

History of substance abuse? YES NO What? _____

Do you live alone? YES NO

When was the last you saw a dentist? _____

Allergies to medications: _____ or None

Have you been diagnosed with Hepatitis C? No Yes When: _____

You should not drink alcohol as it is associated with varying degrees of risk to your health.

Ills in past 12 mos.? No Yes How many times _____ Injury: No Yes _____

Are you currently taking any anti-inflammatory or OTC analgesics medication?

Yes Name of drug: _____

