Date _____ ☐ Male ☐ Female

Name _____ Marital Status _____

Address _____ Occupation _____

_____ Age _____ Date of Birth _____

City State Zip

Home phone _____ Work phone _____

REVIEW OF SYMPTOMS AND PAST MEDICAL HISTORY

SYMPTOMS: Please mark (x) in the available blanks if any of the following apply to you NOW or in the PAST.

NOW	PAST	
		HEAD, EYES, EARS, NOSE THROAT
☐	☐	Dizziness
☐	☐	Severe headaches
☐	☐	Double vision
☐	☐	Poor eyesight
☐	☐	Ear or hearing trouble
☐	☐	Frequent nose trouble
☐	☐	Persistent hoarseness
☐	☐	Teeth trouble
☐	☐	Sore mouth
		LUNGS
☐	☐	Daily cough
☐	☐	Coughing blood
☐	☐	Persistent wheezing
☐	☐	Shortness of breath
☐	☐	Chest pain when breathing
		HEART - CIRCULATION
☐	☐	Chest pain when walking
☐	☐	Heart palpitation
☐	☐	Leg vein trouble
☐	☐	Leg pain when walking
☐	☐	Ankle swelling
		STOMACH - INTESTINAL
☐	☐	Trouble swallowing
☐	☐	Frequent or severe nausea
☐	☐	Frequent or severe heartburn
☐	☐	Frequent indigestion
☐	☐	Frequent or severe stomach pain
☐	☐	Frequent or severe vomiting
☐	☐	Vomiting blood
☐	☐	Yellow jaundice
☐	☐	Bowel habit change
☐	☐	Prolonged or frequent diarrhea
☐	☐	Constipation
☐	☐	Blood in bowel movements
☐	☐	Black bowel movements
☐	☐	Hemorrhoids (piles)

SYMPTOMS (continued)

NOW	PAST	
		URINARY
☐	☐	Frequent urination
☐	☐	Painful urination
☐	☐	Bloody urine
☐	☐	Trouble starting urine
☐	☐	Urinate more than two times a night
☐	☐	Trouble holding urine
		BONES, JOINTS, MUSCLES
☐	☐	Joint pains and swelling
☐	☐	Severe lack of strength
		NERVOUS SYSTEM
☐	☐	Lack of energy
☐	☐	Frequent loss of balance
☐	☐	Fainting spells (blackouts)
☐	☐	Convulsions (seizures, fits, epilepsy)
☐	☐	Tremor (shaking, trembling)
☐	☐	Paralysis
☐	☐	Numbness (body parts “go to sleep”)
☐	☐	Nervousness
☐	☐	Excessive worry
☐	☐	Trouble concentrating
☐	☐	Depression (feeling blue)
☐	☐	Crying spells
☐	☐	Feelings of worthlessness
☐	☐	Trouble getting along with people
		MALES
☐	☐	Discharge from penis
☐	☐	Testicles trouble
☐	☐	Sexual trouble
		FEMALES
☐	☐	Breast lumps or discharge
☐	☐	Unusual bleeding from vagina
☐	☐	Unusual discharge from vagina
☐	☐	Sexual trouble

When was your last pap smear? _____

		GENERAL
☐	☐	Unexplained weight loss or gain

PT.NO.

NAME

DOB

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FAMILY AND PERSONAL HISTORY
DERMATOLOGY

SYMPTOMS (continued)

NOW PAST **GENERAL** (continued)

- ☐ ☐ Unexplained fever
- ☐ ☐ Night sweats
- ☐ ☐ Can't stand hot weather
- ☐ ☐ Can't stand cold weather
- ☐ ☐ Persistent skin rash or itching

PAST MEDICAL HISTORY AND SURGERIES: List type of illness, operation, place and date:

_____

_____

_____

_____

_____

HEALTH HISTORY: Have you had any of the following?

YES NO

- ☐ ☐ Cancer (type) _____
- ☐ ☐ Heart murmur
- ☐ ☐ High blood pressure
- ☐ ☐ Liver disease, yellow jaundice, hepatitis
- ☐ ☐ Mental troubles or nervous breakdown
- ☐ ☐ Pneumonia
- ☐ ☐ Artificial joints or heart valves
- ☐ ☐ Do you take antibiotics when you go to the dentist?
- ☐ ☐ Serious injury/accident
- ☐ ☐ Diabetes
- ☐ ☐ Tuberculosis (TB)
- ☐ ☐ Uncontrolled bleeding
- ☐ ☐ Venereal disease
- ☐ ☐ HIV
- ☐ ☐ Raynaud's (problems with your fingers when you go out in the cold)
- ☐ ☐ Thyroid disease

ALLERGIES: Are you allergic to or have you had a "bad reaction" to any medicine or other substance? ☐ Yes ☐ No

List, if any:

_____

_____

_____

MEDICATIONS: What prescribed medicines are you taking (list dose and frequency)? Include non-prescription medicines.

_____

_____

_____

_____

SKIN HISTORY:

YES NO

- ☐ ☐ Personal history of skin cancer
- ☐ ☐ Family history of skin cancer

if yes, type of skin cancer

- ☐ basal cell carcinoma ☐ melanoma
- ☐ squamous cell carcinoma ☐ unknown

- ☐ ☐ Difficulties with wound healing
- ☐ ☐ Abnormal scarring
- ☐ ☐ Excessive bleeding

Where did you grow up? _____

- ☐ ☐ History of serious sunburn, when? _____
- ☐ ☐ Excessive sun exposure
- ☐ ☐ History of lots of moles
- ☐ ☐ History of tanning beds, ultraviolet lights
- ☐ ☐ Do you use sunscreen regularly?
- ☐ ☐ Do you wear hats in the sun?
- ☐ ☐ History of cold sores
- ☐ ☐ History of skin infection
- ☐ ☐ Radiation, radium exposure
- ☐ ☐ Other skin conditions/problems

_____

_____

_____

SOCIAL HISTORY:

Smoking: ☐ cigarettes ☐ pipe ☐ cigar ☐ none

Number of years: _____ Daily amount: _____

Alcohol: ☐ beer ☐ wine ☐ other liquors ☐ none

Amount per week: _____

Do you use marijuana? ☐ Yes ☐ No

Do you use other recreational drugs? ☐ Yes ☐ No

Hours of sleep per night: _____

Number of meals per day: _____

FAMILY HEALTH HISTORY:

Family Member	Age	If Living Present Health			If Not Living	
		Good	Fair	Poor	Age at Death	Cause of Death
Mother						
Father						
Brothers/ sisters						
Children						

REVIEWED BY MD - SIGNATURE DATE

PT.NO.

NAME

DOB

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