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)

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 nipple discharge
☐ ☐ Unusual bleeding from vagina
☐ ☐ Unusual discharge from vagina
☐ ☐ Sexual trouble
When was your last pap smear? _______________________

GENERAL
☐ ☐ Unexplained weight loss or gain
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

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 ☐ cigars ☐ 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:

<table>
<thead>
<tr>
<th>Family</th>
<th>If Living</th>
<th>If Not Living</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>Present Health</td>
<td>Age at Death</td>
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<tr>
<td>Member</td>
<td>Age</td>
<td>Good</td>
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<td>Mother</td>
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<tr>
<td>Father</td>
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<tr>
<td>Brothers/ Sisters</td>
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<tr>
<td>Children</td>
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PHYSICIAN SIGNATURE | PRINT NAME | UPIN/NPI | DATE | TIME |