

Date _____
 Name _____
 Address _____

City State Zip
 Home Phone _____

Male Female
 Marital Status _____
 Occupation _____
 Age _____ Date of Birth _____
 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 nipple discharge
- Unusual bleeding from vagina
- Unusual discharge from vagina
- Sexual trouble

When was your last pap smear? _____

GENERAL

- Unexplained weight loss or gain

PLACE PATIENT LABEL HERE

UW Medicine

Harborview Medical Center – University of Washington Medical Center
 UW Medicine Primary Care – Valley Medical Center – UW Physicians

FAMILY AND PERSONAL HISTORY DERMATOLOGY

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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 | |
| <input type="checkbox"/> | <input type="checkbox"/> | Cancer (type) _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Heart murmur |
| <input type="checkbox"/> | <input type="checkbox"/> | High Blood pressure |
| <input type="checkbox"/> | <input type="checkbox"/> | Liver disease, yellow jaundice, hepatitis |
| <input type="checkbox"/> | <input type="checkbox"/> | Mental troubles or nervous breakdown |
| <input type="checkbox"/> | <input type="checkbox"/> | Pneumonia |
| <input type="checkbox"/> | <input type="checkbox"/> | Artificial joints or heart valves |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you take antibiotics when you go to the dentist? |
| <input type="checkbox"/> | <input type="checkbox"/> | Serious injury/accident |
| <input type="checkbox"/> | <input type="checkbox"/> | Diabetes |
| <input type="checkbox"/> | <input type="checkbox"/> | Tuberculosis (TB) |
| <input type="checkbox"/> | <input type="checkbox"/> | Uncontrolled bleeding |
| <input type="checkbox"/> | <input type="checkbox"/> | Venereal disease |
| <input type="checkbox"/> | <input type="checkbox"/> | HIV |
| <input type="checkbox"/> | <input type="checkbox"/> | Raynaud's (problems with your fingers when you go out in the cold) |
| <input type="checkbox"/> | <input type="checkbox"/> | 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 (list dose and frequency)? Include non-prescription medicines.

SKIN HISTORY:

- | | | |
|------------------------------|--------------------------|---------------------------------|
| YES | NO | |
| <input type="checkbox"/> | <input type="checkbox"/> | Personal history of skin cancer |
| <input type="checkbox"/> | <input type="checkbox"/> | Family history of skin cancer |
| If yes, type of skin cancer: | | |
| <input type="checkbox"/> | <input type="checkbox"/> | basal cell carcinoma |
| <input type="checkbox"/> | <input type="checkbox"/> | squamous cell carcinoma |
| <input type="checkbox"/> | <input type="checkbox"/> | melanoma |
| <input type="checkbox"/> | <input type="checkbox"/> | unknown |
| <input type="checkbox"/> | <input type="checkbox"/> | Difficulties with wound healing |
| <input type="checkbox"/> | <input type="checkbox"/> | Abnormal scarring |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive bleeding |

Where did you grow up?

- | | | |
|--------------------------|--------------------------|---|
| <input type="checkbox"/> | <input type="checkbox"/> | History of serious sunburn, when? _____ |
| <input type="checkbox"/> | <input type="checkbox"/> | Excessive sun exposure |
| <input type="checkbox"/> | <input type="checkbox"/> | History of lots of moles |
| <input type="checkbox"/> | <input type="checkbox"/> | History of tanning beds, ultraviolet lights |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you use sunscreen regularly? |
| <input type="checkbox"/> | <input type="checkbox"/> | Do you wear hats in the sun? |
| <input type="checkbox"/> | <input type="checkbox"/> | History of cold sores |
| <input type="checkbox"/> | <input type="checkbox"/> | History of skin infection |
| <input type="checkbox"/> | <input type="checkbox"/> | Radiation, radium exposure |
| <input type="checkbox"/> | <input type="checkbox"/> | 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:

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

PHYSICIAN SIGNATURE	PRINT NAME	UPIN/NPI	DATE	TIME
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