Preventive:

Date: _____

Sigmoidoscopy:	_____	Pap smear:	_____	Eye exam:	_____
Mammogram:	_____	Breast exam:	_____	Stool ck for blood:	_____
Colonoscopy:	_____	Prostate exam:	_____	Cholesterol ck:	_____

Family History:

Has any member of the (including parents and siblings) ever had the following?

Illness	Which family member	Age diagnosed
Cancer (describe which type):		
Hypertension (high blood pressure):		
Heart disease:		
Diabetes:		
Stroke:		
Mental disease (anixety, depression etc.):		
Drug or alcohol addiction:		
Glaucoma:		
Bleeding disease:		
Other :		

Review of Systems:

Do you have frequent headaches?	Yes:	☐	No:	☐
Do you have difficulty hearing?	Yes:	☐	No:	☐
Do you have trouble swallowing?	Yes:	☐	No:	☐
Have you had any unintentional weight loss?	Yes:	☐	No:	☐
Do you have difficulty breathing?	Yes:	☐	No:	☐
Do you have frequent chest pain?	Yes:	☐	No:	☐
Do you suffer from frequent abdominal pain?	Yes:	☐	No:	☐
Do you have frequent diarrhea?	Yes:	☐	No:	☐
Are you frequently constipated?	Yes:	☐	No:	☐
Do you suffer from sexual dysfuncton?	Yes:	☐	No:	☐
Are you having trouble walking?	Yes:	☐	No:	☐
Do you have frequent back pain?	Yes:	☐	No:	☐

Please elaborate on any of the above answers: _____

Doctor: _____

Sign: _____ Date: _____

Patient: _____

Date: _____

Personal Information:

Age: _____ DOB: _____ Male: ☐ Female: ☐

Ethnicity: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: _____ Occupation: _____

Work #: _____ Emergency #: _____

How did you hear about us?: _____

Marital Status: _____ Spouse's Name: _____ Age: _____

Email Address: _____

Allergies to medication, X-Ray dyes, or other substances:

If yes, please list name(s) of medicines and types or reaction(s):

Drug Name	Reaction	Drug Name	Reaction
1.		3.	
2.		4.	

Medications (prescriptions over the counter, vitamins, herbs, etc):

Drug Name	Dose	Medication is treating what illness?
1.		
2.		

Past medical history treated or untreated:

Hospitalizations:

Surgical	Date	Surgical	Date
1.		3.	
2.		4.	

Immunization history:

Hepatitis B	Yes:	☐	No: ☐	Pneumovax	Yes:	☐	No: ☐
Flu	Yes:	☐	No: ☐	Tetanus	Yes:	☐	No: ☐
Other:	Yes:	☐	No: ☐	Hepatitus A	Yes:	☐	No: ☐