Identifying Information

First Name:	Middle Name:	Last Name:
Signature:		Date:

Family History

Father: [ ] Living [ ] Deceased [ ] Illness: ______________________________

Mother: [ ] Living [ ] Deceased [ ] Illness: ______________________________

Brother(s) How many Living _____ How many Deceased _____ Illnesses ____________________

Sister(s) How many Living _____ How many Deceased _____ Illnesses ____________________

Social History

Occupation: ________________________ Marital Sta[ ] Single [ ] Married [ ] Widowed [ ] Divorce[ ] ______

Number of Children __________________ Do you Smoke? [ ] Yes [ ] No If yes, how many packs per day __________

How often do you exercise? ____________ Do you Drink? [ ] Yes [ ] No If yes, how much ____________________

Please check box if you have had any problems in any of the designated areas, if normal, check the normal box.

General

[ ] **Normal**
[ ] Fever
[ ] Weight change
[ ] Night sweats
[ ] Chills
[ ] Loss of sleep/fatigue

Breast

[ ] **Normal**
[ ] Lump
[ ] Pain
[ ] Nipple discharge
[ ] Infection

Infections Diseases

[ ] **Normal**
[ ] HIV/AIDS
[ ] Tuberculosis
[ ] Hepatitis A
[ ] Hepatitis B
[ ] Hepatitis C
[ ] STD
[ ] MRSA

Dental

[ ] **Normal**
[ ] Dentures/Gum disease
[ ] Other

Cardiac

[ ] **Normal**
[ ] Pacemaker
[ ] Defibrillator
[ ] Bypass surgery
[ ] High blood pressur
[ ] Heart disease
[ ] Poor circulation
[ ] Heart attack

Pulmonary

[ ] **Normal**
[ ] Cough/Sputum
[ ] Brochitis
[ ] Asthma
[ ] Shortness of breatl
[ ] Pneumonia

Endocrine

[ ] **Normal**
[ ] Diabetes
[ ] Thyroid disease
[ ] High cholesterol

Skin

[ ] **Normal**
[ ] Rash/Bruise easily
[ ] Cancer
[ ] Abnormal moles

Gastointestinal

[ ] **Normal**
[ ] Nausea/vomiting/diarrhe
[ ] Colon polyp or cancer
[ ] Irritable bowel disease
[ ] Poor appetite
[ ] Hiatal herna or reflux
[ ] Ulcer
[ ] Liver disease
[ ] Abdominal pain
[ ] Hernia
[ ] Rectal bleeding/hemorrhoids

GU

[ ] **Normal**
[ ] Kidney disease or kidney sto
[ ] Prostate
[ ] Blood in urine
[ ] Difficulty urinating
[ ] Incontinence

Neurological

[ ] **Normal**
[ ] Stroke/Seizure
[ ] Dizziness/Fainting
[ ] Headaches
[ ] Alzheimer's

Hemotological/Lymphatic

[ ] **Normal**
[ ] Bleeding disorder
[ ] Blood clots
[ ] Swollen lymph nodes
[ ] Anemia
[ ] Blood transfusions

Immune System

[ ] **Normal**
[ ] Previous/Current Cancer
TYPE:__________________
[ ] Allergies

HEENT

[ ] **Normal**
[ ] Hearing loss/hearing aid
[ ] Ear infection
[ ] Sinus problems/Runny nose
[ ] Nose bleed
[ ] Hoarseness/Sore throat
[ ] Blurred or double vision
[ ] Glasses or contacts
[ ] Glaucoma or retinopathy

Musculoskeletal

[ ] **Normal**
[ ] Joint pain/arthritis
[ ] Other

OB-GYN

[ ] **Normal**
[ ] Currently pregnant
[ ] Trying to conceive
1st period _____________
1st pregnancy ___________________
[ ] Breast Feeding
[ ] Menopause
[ ] Hormone therapy
[ ] Family history of breast cancer

Additional Past Medical History - Medical conditions or hospitalizations

Surgeries - Please list procedure (s) and date (s):

Medications you currently take (prescription, "over the counter" and herbal)

Name of Medicine	Dosage	Frequency	Name of Medicine	Dosage	Frequency

Any allergies to medications? [ ] NO [ ] YES, please list medication and reaction.

Prevention (colonoscopy, mammogram, pap smear, lipid panel, etc.)

Colonoscopy: [ ] No [ ] Yes, date ____________

Cholesterol: [ ] No [ ] Yes, date ____________

Other: ______________________________

Other: ______________________________

Pap Smear: [ ] No [ ] Yes, date ____________

Mammogram: [ ] No [ ] Yes, date ____________

Bone Density Scan: [ ] No [ ] Yes, date ____________

Other: __________________________