NAME: _____ DATE: _____ AGE: _____

Reason for this Examination:
Routine (No Symptoms) _____
Main Symptoms: _____

Date of last previous
Physical examination:

SOCIAL HISTORY:
Date of Birth _____ Place of Birth _____
Area where raised _____
Father's Occupation _____
Family live with parents was:
☐ Pleasant ☐ Average ☐ Unpleasant
Highest level of Education _____
Occupation(s) _____

Married _____ Years _____
Previous Marriages _____ Years _____
Spouse's Occupation _____
Military Service _____
Overseas Duty _____
Domestic Problems _____

FAMILY HISTORY:

	If Living Age:	If Living Health:	If Deceased Age:	If Deceased Cause:
Father				
Mother				
Brother or Sister 1.				
2.				
3.				
4.				
5.				
Husband or Wife				
Son or Daughter 1.				
2.				
3.				
4.				
5.				

Has any blood relative Ever had

	No	Yes	Who?
Cancer	☐	☐	
Tuberculosis	☐	☐	
Diabetes	☐	☐	
Heart Trouble	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Psychiatric Trouble	☐	☐	

PAST HISTORY:
CHILDHOOD ILLNESSES:
1. Usual diseases (Mumps, Measles etc.) _____
2. More serious illnesses _____

INJURIES:
1. Broken bones _____
2. Concussion or head injury _____
3. Other _____

ALLERGIES:
☐ Penicillin ☐ Other Antibiotics _____
☐ Morphine ☐ Codeine ☐ Sulfa
☐ Pollens ☐ Foods _____
☐ Other _____

HABITS:
Coffee (cups per day) _____
Alcohol (amount and frequency) _____
Tobacco (kind and amount) _____
Regular Exercise (kind and amount) _____

CURRENT MEDICATIONS:
1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8 _____

SURGERY: (Note type of surgery and year)
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

ADULT ILLNESSES:
1. Chronic or Serious: (give year) _____
2. Illnesses requiring hospitalization (give year) _____
3. HIV Risks and Concerns _____

PLEASE TURN THE PAGE OVER

Yes No **GENERAL:**
- ☐ ☐ Weight Loss
- ☐ ☐ Chills or Fever
- ☐ ☐ Sweats

Yes No **PSYCHIATRIC:**
- ☐ ☐ Tension
- ☐ ☐ Depression

Yes No **NEUROLOGIC:**
- ☐ ☐ Headache
- ☐ ☐ Fainting
- ☐ ☐ Dizziness or Lightheadedness
- ☐ ☐ Coma
- ☐ ☐ Convulsions or Seizures
- ☐ ☐ Numbness or Tingling

Yes No **EARS:**
- ☐ ☐ Disease
- ☐ ☐ Hearing Loss
- ☐ ☐ Ringing or Buzzing

Yes No **EYES:**
- ☐ ☐ Disease
- ☐ ☐ Glasses

Yes No **NOSE:**
- ☐ ☐ Sinusitis
- ☐ ☐ Hay Fever
- ☐ ☐ Other

Yes No **MOUTH and THROAT:**
- ☐ ☐ Disease
- ☐ ☐ Other

Yes No **THYROID**
- ☐ ☐ Disease
- ☐ ☐ Goiter
- ☐ ☐ Thyroid Medication
- ☐ ☐ Excessive Intolerance to:
  - Yes No
  - ☐ ☐ a. Hot Weather
  - ☐ ☐ b. Cold Weather

Yes No **ENDOCRINE:**
- ☐ ☐ Change in Skin or Hair
- ☐ ☐ Diabetes

Yes No **HEMATOLOGY:**
- ☐ ☐ Anemia
- ☐ ☐ Nose Bleeds
- ☐ ☐ Easy Bruising

Yes No **LUNGS:**
- ☐ ☐ Tuberculosis
- ☐ ☐ Pneumonia
- ☐ ☐ Pleurisy
- ☐ ☐ Asthma
- ☐ ☐ Chronic Cough
- ☐ ☐ Sputum
- ☐ ☐ Wheeze
- ☐ ☐ Coughing Up Blood

Yes No **CARDIOVASCULAR:**
- ☐ ☐ High Blood Pressure
- ☐ ☐ Rheumatic Fever
- ☐ ☐ Heart Disease
- ☐ ☐ Chest Pain on Exertion
- ☐ ☐ Shortness of Breath
  - Yes No
  - ☐ ☐ a. On Exertion
  - ☐ ☐ b. At Other Times
- ☐ ☐ Irregular Heart Beat
- ☐ ☐ Racing of Heart
- ☐ ☐ Ankle Swelling
- ☐ ☐ Varicose Veins
- ☐ ☐ Leg Ache or Cramps
- ☐ ☐ Use Heart Medications
  - Yes No
  - ☐ ☐ a. Digitalis
  - ☐ ☐ b. Quinidine
  - ☐ ☐ c. Diuretic
  - ☐ ☐ d. Other

Yes No **DIGESTIVE SYSTEM:**
- ☐ ☐ Good Appetite
- ☐ ☐ Nausea
- ☐ ☐ Vomiting
- ☐ ☐ Heartburn
- ☐ ☐ Difficulty Swallowing Food
- ☐ ☐ Abdominal Pain
- ☐ ☐ Stomach Ulcer
- ☐ ☐ Gallbladder Trouble
- ☐ ☐ Liver Disease
- ☐ ☐ Jaundice
- ☐ ☐ Bowel Problems
- ☐ ☐ Bleeding from Digestive Tract

Yes No **GENITO-URINARY SYSTEM:**
- ☐ ☐ Kidney Disease
- ☐ ☐ Bladder Disease
- ☐ ☐ Prostate Trouble
- ☐ ☐ Burning or Pain on Urination
- ☐ ☐ Urinary Frequency
- ☐ ☐ Urination at Night
- ☐ ☐ Venereal Disease
- ☐ ☐ Sexual Relations ☐ Good ☐ Poor

Yes No **GYNECOLOGICAL SYSTEM** (Women Only)
- ☐ ☐ Miscarriages (Number)
- ☐ ☐ Children Born Alive (Number)
- ☐ ☐ Complications of Pregnancy
- ☐ ☐
- ☐ ☐ Menstrual Cycle:
- ☐ ☐ ☐ Frequency
- ☐ ☐ ☐ Duration
- ☐ ☐ ☐ Regularity
- ☐ ☐ ☐ Last Menstrual Period

Yes No **SKELETAL SYSTEM:**
- ☐ ☐ Arthritis
- ☐ ☐ Gout
- ☐ ☐ Back Problems