

General Information Form

First name: _____ Last name: _____

DOB: _____ Age: _____ SSN: _____

Address: _____

City: _____ State: _____ Zip: _____

Home phone: _____ Work phone: _____

Cell phone: _____ E-mail: _____

Profession: _____

How did you hear about us: _____

In the event we need to contact you, how can we do so (check all that applies):

Phone: Home _____ Work _____ Cell _____ Mail _____ E-mail _____

Emergency contact: _____ Phone _____

Are you interested in receiving our FREE monthly e-newsletter: _____

What is your chief complaint:

HEALTH HISTORY

(Confidential)

Name _____ Today's Date _____

Age _____ Birthdate _____ Date of last physical examination _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year.

<p>GENERAL</p> <p><input type="checkbox"/> Chills</p> <p><input type="checkbox"/> Depression</p> <p><input type="checkbox"/> Dizziness</p> <p><input type="checkbox"/> Fainting</p> <p><input type="checkbox"/> Fever</p> <p><input type="checkbox"/> Forgetfulness</p> <p><input type="checkbox"/> Headache</p> <p><input type="checkbox"/> Loss of sleep</p> <p><input type="checkbox"/> Loss of weight</p> <p><input type="checkbox"/> Nervousness</p> <p><input type="checkbox"/> Numbness</p> <p><input type="checkbox"/> Sweats</p> <p>MUSCLE/JOINT/BONE Pain, weakness, numbness in:</p> <p><input type="checkbox"/> Arms <input type="checkbox"/> Hips</p> <p><input type="checkbox"/> Back <input type="checkbox"/> Legs</p> <p><input type="checkbox"/> Feet <input type="checkbox"/> Neck</p> <p><input type="checkbox"/> Hands <input type="checkbox"/> Shoulders</p> <p>GENITO-URINARY</p> <p><input type="checkbox"/> Blood in urine</p> <p><input type="checkbox"/> Frequent urination</p> <p><input type="checkbox"/> Lack of bladder control</p> <p><input type="checkbox"/> Painful urination</p>	<p>GASTROINTESTINAL</p> <p><input type="checkbox"/> Appetite poor</p> <p><input type="checkbox"/> Bloating</p> <p><input type="checkbox"/> Bowel changes</p> <p><input type="checkbox"/> Constipation</p> <p><input type="checkbox"/> Diarrhea</p> <p><input type="checkbox"/> Excessive hunger</p> <p><input type="checkbox"/> Excessive thirst</p> <p><input type="checkbox"/> Gas</p> <p><input type="checkbox"/> Hemorrhoids</p> <p><input type="checkbox"/> Indigestion</p> <p><input type="checkbox"/> Nausea</p> <p><input type="checkbox"/> Rectal bleeding</p> <p><input type="checkbox"/> Stomach pain</p> <p><input type="checkbox"/> Vomiting</p> <p><input type="checkbox"/> Vomiting blood</p> <p>CARDIOVASCULAR</p> <p><input type="checkbox"/> Chest pain</p> <p><input type="checkbox"/> High blood pressure</p> <p><input type="checkbox"/> Irregular heart beat</p> <p><input type="checkbox"/> Low blood pressure</p> <p><input type="checkbox"/> Poor circulation</p> <p><input type="checkbox"/> Rapid heart beat</p> <p><input type="checkbox"/> Swelling of ankles</p> <p><input type="checkbox"/> Varicose veins</p>	<p>EYE, EAR, NOSE, THROAT</p> <p><input type="checkbox"/> Bleeding gums</p> <p><input type="checkbox"/> Blurred vision</p> <p><input type="checkbox"/> Crossed eyes</p> <p><input type="checkbox"/> Difficulty swallowing</p> <p><input type="checkbox"/> Double vision</p> <p><input type="checkbox"/> Earache</p> <p><input type="checkbox"/> Ear discharge</p> <p><input type="checkbox"/> Hay fever</p> <p><input type="checkbox"/> Hoarseness</p> <p><input type="checkbox"/> Loss of hearing</p> <p><input type="checkbox"/> Nosebleeds</p> <p><input type="checkbox"/> Persistent cough</p> <p><input type="checkbox"/> Ringing in ears</p> <p><input type="checkbox"/> Sinus problems</p> <p><input type="checkbox"/> Vision - Flashes</p> <p><input type="checkbox"/> Vision - Halos</p> <p>SKIN</p> <p><input type="checkbox"/> Bruise easily</p> <p><input type="checkbox"/> Hives</p> <p><input type="checkbox"/> Itching</p> <p><input type="checkbox"/> Change in moles</p> <p><input type="checkbox"/> Rash</p> <p><input type="checkbox"/> Scars</p> <p><input type="checkbox"/> Sore that won't heal</p>	<p>MEN only</p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Erection difficulties</p> <p><input type="checkbox"/> Lump in testicles</p> <p><input type="checkbox"/> Penis discharge</p> <p><input type="checkbox"/> Sore on penis</p> <p><input type="checkbox"/> Other</p> <p>WOMEN only</p> <p><input type="checkbox"/> Abnormal Pap Smear</p> <p><input type="checkbox"/> Bleeding between periods</p> <p><input type="checkbox"/> Breast lump</p> <p><input type="checkbox"/> Extreme menstrual pain</p> <p><input type="checkbox"/> Hot flashes</p> <p><input type="checkbox"/> Nipple discharge</p> <p><input type="checkbox"/> Painful intercourse</p> <p><input type="checkbox"/> Vaginal discharge</p> <p><input type="checkbox"/> Other</p> <p>Date of last menstrual period _____</p> <p>Date of last Pap Smear _____</p> <p>Have you had a mammogram? _____</p> <p>Are you pregnant? _____</p> <p>Number of children _____</p>
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CONDITIONS Check (✓) conditions you have or have had in the past.

<p><input type="checkbox"/> AIDS</p> <p><input type="checkbox"/> Alcoholism</p> <p><input type="checkbox"/> Anemia</p> <p><input type="checkbox"/> Anorexia</p> <p><input type="checkbox"/> Appendicitis</p> <p><input type="checkbox"/> Arthritis</p> <p><input type="checkbox"/> Asthma</p> <p><input type="checkbox"/> Bleeding Disorders</p> <p><input type="checkbox"/> Breast Lump</p> <p><input type="checkbox"/> Bronchitis</p> <p><input type="checkbox"/> Bulimia</p> <p><input type="checkbox"/> Cancer</p> <p><input type="checkbox"/> Cataracts</p>	<p><input type="checkbox"/> Chemical Dependency</p> <p><input type="checkbox"/> Chicken Pox</p> <p><input type="checkbox"/> Diabetes</p> <p><input type="checkbox"/> Emphysema</p> <p><input type="checkbox"/> Epilepsy</p> <p><input type="checkbox"/> Glaucoma</p> <p><input type="checkbox"/> Goiter</p> <p><input type="checkbox"/> Gonorrhea</p> <p><input type="checkbox"/> Gout</p> <p><input type="checkbox"/> Heart Disease</p> <p><input type="checkbox"/> Hepatitis</p> <p><input type="checkbox"/> Hernia</p> <p><input type="checkbox"/> Herpes</p>	<p><input type="checkbox"/> High Cholesterol</p> <p><input type="checkbox"/> HIV Positive</p> <p><input type="checkbox"/> Kidney Disease</p> <p><input type="checkbox"/> Liver Disease</p> <p><input type="checkbox"/> Measles</p> <p><input type="checkbox"/> Migraine Headaches</p> <p><input type="checkbox"/> Miscarriage</p> <p><input type="checkbox"/> Mononucleosis</p> <p><input type="checkbox"/> Multiple Sclerosis</p> <p><input type="checkbox"/> Mumps</p> <p><input type="checkbox"/> Pacemaker</p> <p><input type="checkbox"/> Pneumonia</p> <p><input type="checkbox"/> Polio</p>	<p><input type="checkbox"/> Prostate Problem</p> <p><input type="checkbox"/> Psychiatric Care</p> <p><input type="checkbox"/> Rheumatic Fever</p> <p><input type="checkbox"/> Scarlet Fever</p> <p><input type="checkbox"/> Stroke</p> <p><input type="checkbox"/> Suicide Attempt</p> <p><input type="checkbox"/> Thyroid Problems</p> <p><input type="checkbox"/> Tonsillitis</p> <p><input type="checkbox"/> Tuberculosis</p> <p><input type="checkbox"/> Typhoid Fever</p> <p><input type="checkbox"/> Ulcers</p> <p><input type="checkbox"/> Vaginal Infections</p> <p><input type="checkbox"/> Venereal Disease</p>
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MEDICATIONS List medications you are currently taking

ALLERGIES To medications or substances

FAMILY HISTORY Fill in health information about your family.

Relation	Age	State of Health	Age at Death	Cause of Death	Check (✓) if, your blood relatives had any of the following:	
					Disease	Relationship to you
Father					Arthritis, Gout	
Mother					Asthma, Hay Fever	
Brothers					Cancer	
					Chemical Dependency	
					Diabetes	
					Heart Disease, Strokes	
Sisters					High Blood Pressure	
					Kidney Disease	
					Tuberculosis	
					Other	

HOSPITALIZATIONS **PREGNANCY HISTORY**

Year	Hospital	Reason for Hospitalization and Outcome	Year of Birth	Week in Birth	Complications if any

HEALTH HABITS Check (✓) which substances you use and describe how much you use.

Have you ever had a blood transfusion? Yes No
 If yes, please give approximate dates. _____

Caffeine	
Tobacco	
Drugs	
Other	

SERIOUS ILLNESS/INJURIES	DATE	OUTCOME

OCCUPATIONAL CONCERNS Check (✓) if your work exposes you to the following:

	Stress
	Hazardous Substances
	Heavy Lifting
	Other
	Your occupation:

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____