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Patient History: (Please List Current Problem)

Please list any chronic conditions you suffer from

Please list Medications: _____

Please list Medication Allergies:

Please list hospital admissions:

Year Reason/Operation

Year Reason/Operation

Year Reason/Operation

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				
Mother's Mom				
Mother's Dad				
Father's Mom				
Father's Dad				
Bro/Sis				
Bro/Sis				
Bro/Sis				

Health of children: _____

Do you know of any blood **relative** who has had: (circle and give relationship)

- | | | | | |
|------------------|---------------------|--------------------------|------------------------|-------------|
| Rheumatoid | | Ankylosing | Other | |
| Arthritis_____ | Osteoarthritis_____ | Spondylitis_____ | Arthritis_____ | Stroke_____ |
| Lupus_____ | Gout_____ | Osteoporosis_____ | Psoriasis_____ | Goiter_____ |
| Colitis_____ | Heart disease_____ | Rheumatic Fever_____ | Tuberculosis_____ | Asthma_____ |
| Leukemia_____ | Kidney Disease_____ | Epilepsy_____ | Diabetes_____ | |
| Cancer_____ | Alcoholism_____ | High Blood Pressure_____ | Vasculitis_____ | |
| Sarcoidosis_____ | Fibromyalgia_____ | Multiple Sclerosis_____ | Bleeding tendency_____ | |

Chart #

Date:

Physician's Initials____

SYSTEMIC REVIEW (Please circle all that apply to **YOU**.)

CONSTITUTIONAL

- Recent weight gain amount_____
- Recent weight loss amount_____
- Weakness
- Fatigue
- Fever

EYES

- Dryness
- Itching in eye
- Eye pain
- Redness
- Loss of Vision
- Double blurred vision
- Feels like something in eye

RESPIRATORY

- Wheezing (asthma)
- Shortness of breath
- Difficulty in breathing at night
- Swollen legs and feet
- Cough
- Coughing of blood

GASTROINTESTINAL

- Jaundice
- Nausea
- Vomiting of blood or coffee ground material
- Stomach pain relieved by food or milk
- Heart Burn
- Increasing constipation
- Persistent diarrhea
- Blood in Stools/ Black Stools

GASTROURINARY

- Prostate trouble
- Difficult urination
- Pain or burning on urination
- Blood in urine
- Cloudy urine
- Pus in urine
- Discharge from penis/vagina
- Getting up at night to pass urine
- Vaginal dryness
- Rash ulcers
- Sexual difficulties

EAR-NOSE-MOUTH-THROAT

- Loss of taste
- Bleeding gums
- Difficulty swallowing
- Runny nose
- Frequent sore throats
- Sore tongue
- Ringing in ears
- Loss of Hearing
- Nosebleeds
- Loss of Smell
- Dryness in nose
- Sore in mouth
- Hoarseness
- Dryness of mouth

SKIN AND/OR BREAST

- Easy bruising
- Redness
- Rash
- Hives
- Sun sensitive (Sun Allergy)
- Tightness
- Nodule/Bumps
- Hair Loss
- Pain or color changes of hands or feet in the cold

NEUROLOGICAL

- Headaches
- Dizziness
- Fainting
- Muscle Spasm
- Loss of Consciousness
- Pain/Tingling of hands and feet
- Memory loss
- Night Sweats

PSYCHIATRIC

- Excessive worries
- Anxiety
- Easily losing temper
- Depression
- Agitation
- Difficulty falling asleep
- Difficulty staying asleep

CARDIOVASCULAR

- Pain in chest
- High blood Pressure
- Heart Murmurs
- Irregular heart beat

IMMUNOLOGIC

- Susceptible to infections

MUSCULOSKELETAL

- Frequent sneezing
- Morning stiffness
- Lasting how long
- _____mins_____hrs

- Muscle tenderness
- Muscle weakness
- Joint Swelling

ENDOCRINE

- Excessive thirst

HEMATOLOGIC

- Swollen glands
- Tender glands
- Anemia
- Bleeding tendency
- Transfusion

Smoking: _____ per day _____ # of years
Alcohol: _____ per week Coffee/Tea: _____ cups per day
Exercise _____ minutes _____ times per week

Date of last BONE DENSITY: _____

FEMALES: Menstrual History

Regular _____ Irregular _____ Date of last menstrual period _____
Pain/Cramps with menstrual flow _____ Flushing _____ Menopause _____
Date of Last Pap Test _____ Date of last mammogram _____
of pregnancies _____ #live births _____ # of miscarriages _____
Birth control method _____

Please bring all your recent Xrays and lab work along with you.

Chart #

Date:

Physician's Initials _____