Name:_____ **Date of Birth**:_____

CHECK ALL THAT APPLY:

Past Medical History

- ☐ Heart Attack
- ☐ Stroke
- ☐ Mini Stroke (TIA)
- ☐ High Blood pressure
- ☐ Diabetes
- ☐ High Cholesterol
- ☐ Kidney Stones
- ☐ Kidney Cysts
- ☐ Protein in the urine
- ☐ Blood in the urine
- ☐ Lupus
- ☐ Gout
- ☐ Cancer
- ☐ Sickle cell disease
- ☐ Multiple myeloma
- ☐ Thyroid disease
- ☐ Hepatitis
- ☐ Cirrhosis of the liver
- ☐ HIV disease
- ☐ Procedures requiring contrast dye
- ☐ History of sexually transmitted disease
- ☐ Anemia
- ☐ Frequent kidney infection

Please list all operations and date:

_____

_____

_____

Family History:

Has any member of your family had the following medical problems?

- ☐ Kidney failure requiring dialysis
- ☐ Kidney stones
- ☐ Diabetes
- ☐ Severe arthritis involving many joints
- ☐ High blood pressure
- ☐ Hearing loss
- ☐ Cysts involving the kidney or liver
- ☐ Brain aneurysms
- ☐ Cholesterol problems
- ☐ Thyroid disease
- ☐ Clotting or bleeding problems
- ☐ Heart attack or stroke at a young age men < 55, women < 80
- ☐ Lupus
- ☐ Cancer
- ☐ Sickle cell disease

Family Health Status:

Mother: ☐Living ☐Deceased Age _____
Causes of death _____

Father: ☐Living ☐Deceased Age _____
Causes of death_____
Number of siblings BROs:_____SIS:_____
Number of deceased siblings BRO:_____SIS:_____
Cause of deaths_____

Social History:

Marital Status: ☐ M ☐W ☐D ☐S ☐Sep.
# of children_____
Years of formal education_____

Habits:

- ☐ Alcohol_____
- ☐ Tobacco products?_____
- ☐ Caffeine consumption?_____
- ☐ Street drugs
- ☐ Regular exercise_____

Health Maintenance:
Mammogram_____
Prostate exam_____
Stool check for blood_____
Flex Sig/Colonoscopy_____

Ob-GYN History:

How many pregnancies have you had?_____
How many deliveries?_____
Have you experienced menopause?_____
Date of last period._____
Did you have problems with blood pressure during your pregnancy?_____
Did you have problems with your kidneys during your pregnancy?_____

Sexual History:
Have you had an HIV test before_____
When?_____

High risk sexual behavior_____
History of sexually transmitted disease?

MD Signature_____
Date_____

NAME:_____ DATE OF BIRTH:_____

Review of Systems

CHECK ALL THAT APPLY:

GEN
- ☐ Persistent fever
- ☐ Fatigue
- ☐ Weight loss
- ☐ Night sweats

Eyes
- ☐ Double Vision
- ☐ Blurred Vision
- ☐ Eye pain
- ☐ Eye redness
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Loss of Vision
- ☐ Eye surgery
- ☐ Laser Surgery
- ☐ Dry eyes

Ears/Nose/Throat
- ☐ Loss of hearing
- ☐ Vertigo
- ☐ Ringing in ears
- ☐ Hoarseness
- ☐ Excessively dry mouth
- ☐ Nasal ulcer
- ☐ Nosebleeds
- ☐ Earaches
- ☐ Pain w/ swallowing
- ☐ Ulcers in the mouth

Heart
- ☐ Chest pain at rest
- ☐ Chest pain with activity
- ☐ Feeling faint
- ☐ Heart murmur
- ☐ Heart valve problems
- ☐ Congestive heart failure
- ☐ Inability to finish task in the past
- ☐ Coughing
- ☐ History of rheumatic fever
- ☐ History of strep throat
- ☐ High blood pressure
- ☐ Problems walking due to Calf pain
- ☐ Leg or ankle swelling
- ☐ Varicose veins
- ☐ Mitral Valve prolapsed
- ☐ His of heart stress test If so when_____
- ☐ History of heart cath If so when

Lungs
- ☐ Coughing
- ☐ Shortness of breath at rest
- ☐ Coughing up blood
- ☐ Sharp chest pain when inhaling
- ☐ Wheezing
- ☐ Tobacco use
- ☐ History of asthma
- ☐ Hay fever
- ☐ Pneumonia
- ☐ Bronchitis
- ☐ Tuberculosis or exposed to anyone with TB
- ☐ Positive TB skin test
- ☐ History of having abnormal chest x-ray
- ☐ Sinus infections
- ☐ Sore throat

Stomach
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Unexplained weight loss
- ☐ Loss of appetite
- ☐ Ulcers reflux
- ☐ Dark stools resembling tar
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Jaundice
- ☐ Gallstones
- ☐ Metallic or taste of foods
- ☐ Abdominal surgeries

Muscles and Joints
- ☐ Muscle aches
- ☐ Joints aches
- ☐ Leg cramps
- ☐ Gout
- ☐ Arthritis

Nerves
- ☐ Numbness or tingling of the hands or feet
- ☐ Problems sleeping
- ☐ Restless legs at night
- ☐ Anxiety
- ☐ Depressed mood
- ☐ Dizziness when standing
- ☐ Fainting spells
- ☐ Seizures
- ☐ Weakness

Skin
- ☐ Dry itchy skin
- ☐ New rashes
- ☐ Yellowing of the eyes
- ☐ Ulcers in the mouth
- ☐ Hair loss
- ☐ Skin infections
- ☐ Boils abscess
- ☐ Bruises
- ☐ Hives

Blood system
- ☐ Bruising easily
- ☐ Bleeding gums
- ☐ History of clots in the legs or lungs
- ☐ Prolongs bleeding
- ☐ Swollen glands

Endocrine
- ☐ Excessive thirst
- ☐ Weight loss
- ☐ Cold or heat intolerance
- ☐ Cholesterol problems
- ☐ History of thyroid disease
- ☐ History of high or low calcium levels
- ☐ Osteoporosis
- ☐ History of high or low potassium

Psychiatry
- ☐ Depression
- ☐ Agitation
- ☐ Anxiety or panic attacks
- ☐ Memory problems
- ☐ Hallucinations

Discussions of positives:

_____

_____

MD SIGNATURE_____ **DATE**_____