

Medical Problems: Have you had or do you have any of the following medical problems:

Yes No

\_\_\_ High Blood Pressure  
\_\_\_ Heart Disease  
\_\_\_ Heart Attack  
\_\_\_ Stroke  
\_\_\_ Diabetes  
\_\_\_ Thyroid Disease

Yes No

\_\_\_ Breast Cancer  
\_\_\_ Colon Cancer  
\_\_\_ Other Cancer  
\_\_\_ Abnormal PAP  
\_\_\_ Hepatitis/Jaundice  
\_\_\_ Liver/Pancreas Disease

Yes No

\_\_\_ Asthma  
\_\_\_ Emphysema  
\_\_\_ Tuberculosis  
\_\_\_ Sickle Cell  
\_\_\_ Anemia  
\_\_\_ Arthritis

Will you accept blood transfusions in an EMERGENCY situation? **Y** **N**

Past Surgery: Have you had any of the following operations and the year:

___ Appendix ___ year	___ Gallbladder ___ year	___ Hysterectomy ___ year
___ Hernia ___ year	___ Heart ___ year	___ Other: _____
___ Tonsils ___ year	___ Thyroid ___ year	_____
___ Lung ___ year	___ Spine/Joint ___ year	_____

Family Medical History:

Father \_\_\_\_\_  
Mother \_\_\_\_\_  
Sibling \_\_\_\_\_  
Sibling 2 \_\_\_\_\_  
Sibling 3 \_\_\_\_\_

What is the reason for this visit? (Please specify)

\_\_\_\_\_

Allergic to any medications?

\_\_\_\_\_

### Review of Symptoms

#### General

\_\_\_ Weakness  
\_\_\_ Chills  
\_\_\_ Fever  
\_\_\_ Weight Change  
\_\_\_ Night Sweats  
\_\_\_ Fatigue

#### Head

\_\_\_ Headaches  
\_\_\_ Dizziness  
\_\_\_ Fainting  
\_\_\_ Head trauma

#### Eyes

\_\_\_ Change in vision  
\_\_\_ Double Vision  
\_\_\_ Blurriness  
\_\_\_ Tearing  
\_\_\_ Glasses

#### Lungs

\_\_\_ Cough  
\_\_\_ Shortness of Breath  
\_\_\_ Wheezing  
\_\_\_ Coughing up blood

#### Gastrointestinal

\_\_\_ Change in appetite  
\_\_\_ Pain or difficulty in swallowing  
\_\_\_ Nausea  
\_\_\_ Vomiting  
\_\_\_ Heartburn  
\_\_\_ Vomiting Blood  
\_\_\_ Constipation

\_\_\_ Diarrhea  
\_\_\_ Jaundice

#### Nervous System

\_\_\_ Seizures  
\_\_\_ Numbness/Tingling  
\_\_\_ Loss of Balance  
\_\_\_ Loss of Strength  
\_\_\_ Paralysis  
\_\_\_ Tremors  
\_\_\_ Mood Changes  
\_\_\_ Memory Loss

#### Musculoskeletal

\_\_\_ Joint Stiffness  
\_\_\_ Pain  
\_\_\_ Swelling  
\_\_\_ Muscle Aches  
\_\_\_ Temp. Differences  
\_\_\_ Redness

#### Endocrine

\_\_\_ Urinating more often  
\_\_\_ Thirsty  
\_\_\_ Hungry  
\_\_\_ Nervousness  
\_\_\_ Unexplained Weight change

#### Female

\_\_\_ Number of Pregnancies  
\_\_\_ Number of Children  
\_\_\_ C-Sections  
\_\_\_ Stillbirths  
\_\_\_\_\_ Last Menstrual Cycle  
\_\_\_\_\_ Last Pap Smear