



## Allergies and Sensitivities

List any allergies to medications or foods that you may have and indicate how each affects you.

Allergic To	Reaction

No known drug allergies

## Family History

Father                    \_\_\_ Living            \_\_\_ Deceased - Age at Death \_\_\_            Cause \_\_\_\_\_

Mother                   \_\_\_ Living            \_\_\_ Deceased - Age at Death \_\_\_            Cause \_\_\_\_\_

List any other illnesses in your family (grandmother, grandfather, sister, brother, aunt, uncle, cousin, son, daughter) including diabetes, heart disease, cancer, stroke, thyroid problems, etc.

Family Member

\_\_\_\_\_                \_\_\_ Living            \_\_\_ Deceased - Age at Death \_\_\_            Illness \_\_\_\_\_

\_\_\_\_\_                \_\_\_ Living            \_\_\_ Deceased - Age at Death \_\_\_            Illness \_\_\_\_\_

\_\_\_\_\_                \_\_\_ Living            \_\_\_ Deceased - Age at Death \_\_\_            Illness \_\_\_\_\_

\_\_\_\_\_                \_\_\_ Living            \_\_\_ Deceased - Age at Death \_\_\_            Illness \_\_\_\_\_

## Social History

Marital Status: \_\_\_ Single    \_\_\_ Married    \_\_\_ Widowed    \_\_\_ Divorced    Number of children \_\_\_\_\_

Occupation: \_\_\_\_\_ Are you currently employed: \_\_\_ Yes    \_\_\_ No

Any occupational hazards (like noise or chemical exposures): \_\_\_ Yes    \_\_\_ No    If Yes, what: \_\_\_\_\_

Do you/Did you smoke: \_\_\_ Yes    \_\_\_ No    How much \_\_\_\_\_ # of years \_\_\_\_\_ When did you stop? \_\_\_\_\_

Do you/Did you drink: \_\_\_ Yes    \_\_\_ No    How much \_\_\_\_\_ # of years \_\_\_\_\_ When did you stop? \_\_\_\_\_

### Females

Age @ first period \_\_\_\_\_ Age @ last period \_\_\_\_\_ # of pregnancies \_\_\_\_\_ # of live births \_\_\_\_\_

Age at first pregnancy \_\_\_\_\_

## Pain Assessment

Do you have pain now? \_\_\_ No    \_\_\_ Yes

Location of pain: \_\_\_\_\_

Describe your pain (burning, aching, stabbing, dull, or crushing): \_\_\_\_\_

What causes increase in your pain? \_\_\_\_\_

What do you do to relieve your pain? \_\_\_\_\_

What medications do you take for pain? \_\_\_\_\_

Do you have any ongoing pain problems?

Are you satisfied with your pain control:

\_\_\_ No    \_\_\_ Yes    How long? \_\_\_\_\_

\_\_\_ No    \_\_\_ Yes

Rate intensity of pain (0-10) with 10 being most severe

On a 0-10 scale, what is your level of pain when it

Now \_\_\_ Usual \_\_\_

is at its best? \_\_\_\_\_

On a 0-10 scale, at what level of pain are you able to function as you want? \_\_\_\_\_

## Nutritional History

Has there been a change in your appetite in the past 6 months: \_\_\_\_ Yes \_\_\_\_ No

Have you gained or lost weight (more than 10 lbs) in 1 month without wanting to? \_\_\_\_ Yes \_\_\_\_ No

If Yes, how much gain or loss? \_\_\_\_\_

Are you happy with your weight? \_\_\_\_ Yes \_\_\_\_ No

If not, are you on a diet and exercise program? \_\_\_\_ Yes \_\_\_\_ No

For women: Are you taking any extra calcium? \_\_\_\_ Yes \_\_\_\_ No

## REVIEW OF SYSTEMS

**Instructions:** Check the box for each symptom that you have now or have had in the past three months

### General

- weakness
- chills
- change in weight, appetite, or sleep habits

### Eyes:

- glasses or contacts
- blank spots in your field of vision
- excessive tearing or discharge
- eye pain
- double vision
- last eye exam, date: \_\_\_\_\_

### Ears, Nose, Sinuses, Mouth & Throat

- loss or trouble hearing
- ringing
- frequent earaches
- post nasal drip
- sinus pain
- hoarseness
- bleeding gums
- last dental exam
- drainage
- nosebleed
- blockage of nose
- sore throat
- dentures
- toothache

### Lungs:

- cough
- shortness of breath
- positive TB test
- last chest x-ray, date: \_\_\_\_\_
- wheezing
- spitting up blood

### Heart:

- chest pain
- palpitations (heart pounding)
- trouble breathing at night
- ankle swelling
- fatigue easily with exercise

### Skin:

- itching
- change in color
- changes in warts, moles, or birthmarks
- rash

### Breasts:

- lumps in breast
- discharge from nipple
- last mammogram date: \_\_\_\_\_

### Gastrointestinal:

- vomiting
- difficulty swallowing
- stomach or abdominal pain
- indigestion or heartburn
- blood in stools (or black stools)
- sigmoid or colonoscopy, date: \_\_\_\_\_
- ulcers
- hemorrhoids
- changes in bowel habits

### Musculoskeletal:

- pain
- weakness
- deformity
- joint swelling
- stiffness
- twitching
- chronic back pain
- decreased range of m

### Vaginal and Urinary (female):

- vaginal itching or burning
- vaginal discharge
- sexually transmitted diseases
- sexual difficulties
- problems with menstrual periods
- problems during pregnancy
- pain or frequent urination
- previous urinary infections
- blood in urine
- kidney stones
- trouble starting steam
- incontinence (leaking)
- last Pap, date: \_\_\_\_\_

### Genitals and Urinary (male):

- hernia
- discharge from penis
- pain or lump in testicles
- methods of contraception:
- sexual difficulties
- sexually transmitted diseases
- pain or frequent urination
- previous urinary infections
- blood in urine
- kidney stones
- trouble starting steam
- incontinence
- last PSA, date: \_\_\_\_\_

### Hematologic and Lymphatic:

- easy bruising or bleeding problems
- swollen lymph nodes

### Endocrine:

- Excessively hot
- excessively cold
- always thirsty
- always hungry

### Nervous System:

- headaches
- head injury
- dizziness or passing out
- numbness
- seizures
- loss of coordination/b:

### Psychological:

- nervousness or anxiety
- depression
- nightmares
- unable to sleep
- memory loss