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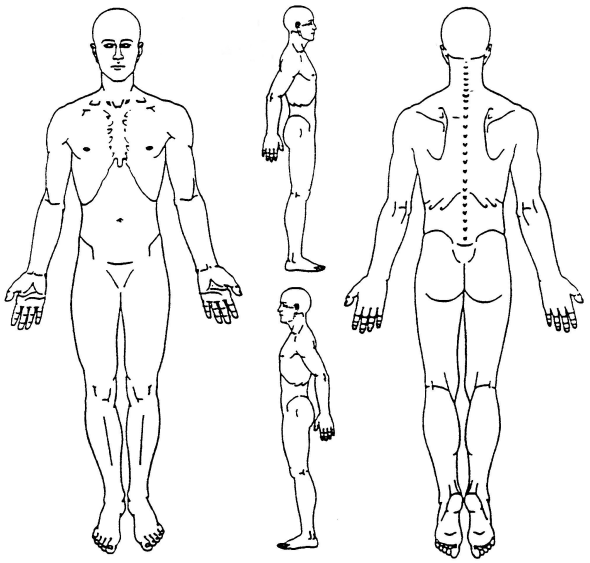
MEDICAL HISTORY

Name _____ Date _____ /_____ / _____
Address _____ City _____ State _____ Zip _____
Phone No. (____) _____Work No. (____) _____ E-mail _____
Age _____ Sex _____ Height _____' _____" Weight _____ lb Date of Birth _____ /_____ / _____
Time of birth _____ AM/PM Place of birth _____
Marital Status _____ Occupation _____ Employer _____
Party responsible for payment _____ Primary care physician _____
In case of emergency notify _____ Phone _____ Relationship _____
How did you hear about this office? _____
Diagnosis/major health complaint _____
Health professionals seen for this condition _____
How, when, and where did this condition begin _____
How does this condition impair daily activities _____
Please list the main health problems you would like to be free of, in order of importance:
1. _____
2. _____
3. _____

Please mark or color in all areas of pain or discomfort on the diagram to the right.



Pain is (check all that apply):

Sharp [ ] Burning [ ] Moving [ ]

Fixed [ ] Dull [ ] Aching [ ] Stabbing [ ]

Radiates to : _____

Men only fill in this portion:

Do you ever experience burning, urgency, or other discomfort during urination? Yes [ ] No [ ]
Have your ever been diagnosed with prostatitis? Yes [ ] No [ ]
Do you have any concerns about sexual function? Yes [ ] No [ ]

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Women only fill in this portion:

Is there a chance you are pregnant now? Yes [ ] No [ ]

Age at first period _____ How long is your monthly cycle? _____

How many days does your period flow? _____ Number of pregnancies _____

Family History

Father	[ ]	Living Age ____	Deceased - age at death ____	Cause _____
Mother	[ ]	Living Age ____	Deceased - age at death ____	Cause _____
Other Parent	[ ]	Living Age ____	Deceased - age at death ____	Cause _____
Spouse	[ ]	Living Age ____	Deceased - age at death ____	Cause _____
Siblings	[ ]	Gender _____	Health Status _____	
Children	[ ]	Gender _____	Health Status _____	

Check illness (es) which have occurred in any of your blood relatives:

[ ] Alcoholism	[ ] Allergy	[ ] Heart Disease	[ ] Kidney Disease
[ ] Obesity	[ ] Diabetes	[ ] Epilepsy	[ ] Stroke
[ ] Bleed easily	[ ] Cancer	[ ] Kidney Disease	[ ] High Blood Pressure
[ ] Other _____			

Personal History

How would you describe your health as a child? _____

_____

Check any illnesses or conditions you have or had in the past?

[ ] AIDs/HIV	[ ] Alcoholism	[ ] Allergies	[ ] Antibiotic use
[ ] Bleed Easily	[ ] Cancer	[ ] Chicken Pox	[ ] Diabetes
[ ] Glaucoma	[ ] Heart Disease	[ ] Hepatitis	[ ] High Blood Pressure
[ ] Jaundice	[ ] Kidney Disease	[ ] Measles	[ ] Meningitis
[ ] Multiple sclerosis	[ ] Mumps	[ ] Pacemaker	[ ] Pneumonia
[ ] Rheumatic fever	[ ] Scarlet fever	[ ] Stroke	[ ] Thyroid disorders
[ ] Typhoid fever	[ ] Ulcers	[ ] Vascular disease	[ ] Venereal disease
[ ] Asthma	[ ] Epilepsy	[ ] Polio	
[ ] High Fevers	[ ] Mental Disorder	[ ] Tuberculosis	

List illnesses not requiring surgery for which you have been hospitalized _____

_____

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List illnesses requiring surgery (including date)_____

_____

List any other serious injury, broken bones, scars, etc. _____

_____

List allergies or sensitivity to any medicines or other substances: _____

_____

List current medication, herbs, and supplements you are taking, with dosages:

_____

_____

_____

_____

_____

List, date and results of last medical test:

Date	Test	Result	Date	Test	Result
	Physical			**Stool**	
	Cholesterol			**HIV Test**	
	Hepatitis			**PSA (Prostate)**	
	Mammography			**Pap Smear**	
	Other:			**Other:**	

Patient Signature _____ Date _____

Consent to treat a minor. Child's name _____

Parent/Legal Guardian Signature _____Date _____