

Reason you came to the Practitioner _____

Have you had:	YES	NO
Recent gain or loss in weight	___	___
Any eye disease or impaired sight	___	___
Any ear disease or impaired hearing	___	___
Trouble with nose, sinuses, mouth or throat	___	___
Stroke	___	___
Seizures (convulsions)	___	___
Severe headaches	___	___
Difficulty swallowing	___	___
Shortness of breath	___	___
Frequent cough	___	___
Coughing up blood	___	___
Pneumonia	___	___
Asthma	___	___
Heart attack or Angina	___	___
Chest pains	___	___
Palpitations (fluttering heart)	___	___
Gallstones	___	___
Abdominal pain	___	___
Ulcers	___	___
Constipation	___	___
Diarrhea	___	___
Blood in stool	___	___
Hemorrhoids	___	___
Difficulty urinating	___	___
Kidney stones	___	___
Blood in urine	___	___
Arthritis	___	___
Edema (swelling)	___	___
Anemia	___	___
Jaundice or liver disease	___	___
TB	___	___
Diabetes	___	___
High blood pressure	___	___
Cancer	___	___
Thyroid disease	___	___
Skin disease	___	___
Problem with nerves	___	___

History of STD:
 PID ___ Dates _____
 Herpes ___ Dates _____
 Genital warts ___ Dates _____
 Chlamydia ___ Dates _____
 GC ___ Dates _____
 HIV ___ Dates _____
 Hepatitis B/C ___ Dates _____

What medications do you take: _____

Any drug allergies: _____ Reaction: _____

Operations: _____

History of tobacco use: Yes__ No__ Quit/when _____
 How much: _____

Any known environmental exposures: _____

FAMILY HISTORY	Yes	No	Explain
Female related cancer	___	___	_____
Thyroid disorder	___	___	_____
Heart disease	___	___	_____
Migraine	___	___	_____
Clotting disorder	___	___	_____
Colon cancer	___	___	_____
Seizures	___	___	_____

For women:
 Birth control methods _____
 When was last period _____
 Total number of pregnancies _____
 Any female problems: _____

 Any menstrual problems: _____

Any abnormal:
 Pap smears Yes___ No___ Dates _____
 Explain _____
 Breast exams/biopsies Yes___ No___ Dates _____
 Explain _____
 Mammograms Yes___ No___ Dates _____
 Explain _____
 Bone density Yes___ No___ Dates _____
 Explain _____