Patient Name:_____ Age:___ Date:_____

DISH

ALLERGY/ SINUSES	Yes	No
Runny nose		
Watery eyes		
Sinus pressure/congestion		
Reactions to food or medicine		
Sensitivity to the environment (heat, cold, etc.), allergens, sprays, etc. Which ones?		

CONSTITUTIONAL	Yes	No
Unexplained weight gain or loss		
fevers		
chills or sweats.		

NEUROLOGIC	Yes	No
Headaches		
blurred or recent change in vision		
cataracts		
glaucoma		
decreased hearing		
ringing or pain in ears		
taste or smell problems		
dizziness or weakness		
Tingling or numbness		

RESPIRATORY	Yes	No
Shortness of breath		
Mucus in your chest, throat, nose		
chest pain when you breathe		
difficulty breathing when you exert yourself		
wheezing		
Tuberculosis		
pneumonia		
asthma		
valley fever		
snoring		

CARDIOVASCULAR	Yes	No
chest pain, aching, pressure, burning, squeezing		
swelling of your feet or legs		
difficulty breathing when you lie down		
difficulty breathing at night		
irregular heart beat		
arm, neck or jaw discomfort with or w/o exertion		

GASTROINTESTINAL	Yes	No
difficulty swallowing		
heartburn, regurgitation or reflux		
abdominal pain, discomfort, or cramping		
bloody or black stool		
diarrhea		
constipation		
hepatitis or jaundice, yellow skin or eyes		
prior blood transfusion		

	Yes	No
rectal pain, burning or itching		
persistent tapering of stools, i.e., becoming "ribbon like" and narrow without normalization		
number of BMs per day		
stool consistency. (hard, soft)		
Stool incontinence (poor control)		

UROLOGIC	Yes	No
Getting up to urinate at night		
Urinating more often		
Pain with urination		
difficulty with erections		
incontinence		

MUSCULOSKELETAL	Yes	No
pain/discomfort of arms, legs, back, neck		
Swelling or stiffness		

DERMATOLOGIC	Yes	No
moles, that increase in size, change color, bleed or become irritated, darkening of the mole or moles that won't heal		
red or dark flaky spots on face, arms or legs-sun exposed areas		
rashes, itching, growths		

HEMATOLOGIC/ONCOLOGIC	Yes	No
easy bruising or bleeding,		
lumps or bumps in the head, neck, arms, groin or breast area.		

For Women

Age you started periods	
Age you stopped	
# of pregnancies	
# of deliveries	
Date of last mammogram	
Are you having vaginal discharge or discomfort?	

Social History

Birth place:
Married Single Divorced Widowed
Education:
Occupation:
Coffee: # of cups
Soda: #
Tea: #
Alcohol # of drinks how often
Smoking: #packs per day # of years
Drugs:
Healthy diet yes no
Sleeping well yes no
Exercise: what/how often:

Patient stop here

Family History

	Yes	No	Who
Glaucoma			
Migraine			
Parkinsons disease			
Muscular dystrophy			
Alcoholism			
Alzheimers			
Schizophrenia			
Deaf			
Heart disease (how old?)			
Diabetes			
Tuberculosis			
Kidney Disease			

	Yes	No	Who
Breast cancer			
Ovary cancer			
Colon cancer			
Melanoma			
Prostate cancer			
Anemia			

Father
Mother

Sons
Daughters

Brothers
Sisters

General: alert and oriented, well developed, well nourished

AUDITORY ACUITY: normal _____

HEENT: normal_____

NECK: normal _____

BREAST/AXILLAE: normal _____

LUNGS: CTAB_____

HEART: RRR no murmur_____

ABDOMEN: soft, NT, +BS_____

GENITALIA: normal _____

RECTAL: guiac negative _____

EXTREMITIES:_____

SPINE AND BACK:_____

SKIN, HAIR, & NAILS:_____

NEUROLOGICAL_____

A/P:_____

_____

_____

_____

Vaccines

	Date of last	Needs
Tetanus		
Pneumonia		
Shingles		
Influenza		
Meningitis		

Prevention

	Date of last	Needs
Colonoscopy		
DEXA		
Echo		
ETT		
Sesta		
Mammo		
CXR		

Diet	NFP 1 2 3 4
Exercise	
Dental	
eye	
ASA	

Rachel Ambrosia revised 05/21/10