Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# DETAILED PATIENT INFORMATION

Please list any medical problems/ diseases that you have:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all medications, herbs, vitamins and over-the-counter products you are taking:

|  |  |  |
| --- | --- | --- |
| **Name** | **Dose/Strength** | **How often you take it** |
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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all allergies to medications, foods, chemicals, plants and the reactions you have:

|  |  |
| --- | --- |
| **Allergy** | **Reaction** |
|  |  |
|  |  |
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# FAMILY HISTORY

Please list all family members including mother, father, sisters, and brothers:

Check here if adopted

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Family member** | **Name** | **Medical Problems** | **Age** | **Deceased** |
|  |  |  |  |  |
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Any diseases/illnesses that run in the family (Cancer, Diabetes, Heart Disease, etc):

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# SURGICAL HISTORY

Please list all surgeries or procedures you have had done:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date** | **Type of Surgery/Procedure** | **Reason for Procedure** | **Hospital** | **Name of Surgeon** |
|  |  |  |  |  |
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Please list all medical specialists that you see:

|  |  |
| --- | --- |
| **Name of Doctor** | **Specialty** |
|  |  |
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Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**SOCIAL HISTORY**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Birthplace: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Level of education completed: \_\_\_\_\_\_\_\_\_\_

What you do for work: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Marital Status

Current status: Divorced Married Single Widowed

Do you live alone: Yes No

Previously widowed: Yes No Previously divorced: Yes No

## Children

Yes No

Number of sons: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Number of daughters: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Tobacco

Are you a smoker: Yes No Former Passive smoker exposure: Yes No

Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Packs/day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Years smoked: \_\_\_\_\_\_ Year Quit: \_\_\_\_\_ Ever tried to quit: Yes No

## Caffeine

Do you drink caffeine: Yes No

Type: Chocolate Coffee Soda Tablets Tea

## Alcohol

Do you drink alcohol: Yes No Formerly Year Quit: \_\_\_\_\_\_\_\_

Type: Beer Hard Liquor Wine

Frequency: \_\_\_\_\_\_\_\_\_\_\_\_ Amount: \_\_\_\_\_\_\_\_\_\_\_ Last drink: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Lifestyle

Activity level: Sedentary Moderate Vigorous

Health club member: Now Previously Never

Type of exercise: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Exercise Frequency: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Hours/week: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hobbies/Activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specific type of diet: Low fat Low carb Diabetic Weight watchers

Animals in the home Yes No Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you the one who cleans up after the animal: Yes No

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Recent Travel

Any recent travel out of the state Yes No Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any recent travel out of the country Yes No Where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## Safety

Are there smoke detectors in the home? Yes No

Are there carbon monoxide detectors in the home? Yes No

Is there radon in the home? Yes No

Do you have firearms in the home? Yes No

Do you wear a seatbelt? Yes No

## Advanced Directives in Place

Mark the advanced directives that you currently have in place:

None DNR Living Will Durable Power of Attorney HC Proxy

Do you agree to a transfusion? Yes No

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HEALTH MAINTENANCE**

Please fill in the date of your most recent health maintenance event (if applicable):

|  |  |
| --- | --- |
| **Event** | **Date of Last** |
| Colonoscopy/ GI procedure |  |
| Stress test/ Cardiac procedure |  |
| Echocardiogram |  |
| Eye exam |  |
| Skin exam |  |
| Mammogram/ Breast exam |  |
| Pap-smear |  |
| PSA/ Prostate exam |  |
| Rectal exam/ Stool cards/ FOBT |  |
| Bone Density |  |

|  |  |
| --- | --- |
| **Vaccine/ Immunization** | **Date of Last** |
| Tetanus (Td) |  |
| Pneumonia vaccine |  |
| Flu vaccine |  |
| Hepatitis A vaccine |  |
| Hepatitis B vaccine |  |
| TB/ PPD (Tuberculosis screening) |  |
| MMR (Measles, Mumps & Rubella) |  |
| Zostavax |  |

**Infectious Disease History**

Do you have any history of blood/ blood product transfusion? If so, when and for what reason?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any history of tick bites, Lyme disease, Rocky Mountain Spotted Fever, or Ehrlichiosis? If so, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever had a positive PPD test (Tuberculosis screening)? If so, what happened as a result of that positive test?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Any concern for possible HIV infection? If so, please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Gynecological History (Females)**

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Number of Pregnancies | Number of Premature Births | Number of C-Sections | Number of Vaginal Births | Number of Life Births | Number of Births at Term | Number of Children Currently Living |
|  |  |  |  |  |  |  |

|  |  |  |
| --- | --- | --- |
| Number of Ectopic Pregnancies | Number of Miscarriages | Number of Abortions |
|  |  |  |

Check here if currently pregnant

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**REVIEW OF SYSTEMS**

Have you experienced any of the following symptoms in the past month?

|  |  |  |
| --- | --- | --- |
| Activity change | No | Yes |
| Chills | No | Yes |
| Decreased appetite | No | Yes |
| Fatigue | No | Yes |
| Fever | No | Yes |
| Insomnia | No | Yes |
| Irritability | No | Yes |
| Malaise/ feeling unwell | No | Yes |
| Night sweats | No | Yes |
| Abnormal paleness | No | Yes |
| Weakness | No | Yes |
| Weight gain | No | Yes |
| Weight loss | No | Yes |

CONSTITUTIONAL HEENT continued…

|  |  |  |
| --- | --- | --- |
| Radical keratotomy | No | Yes |
| Lasik | No | Yes |
| Last eye exam |  |  |
| Ear discharge | No | Yes |
| Cerumen/ ear wax | No | Yes |
| Ear fullness | No | Yes |
| Hearing loss | No | Yes |
| Noise exposure | No | Yes |
| Ear pain | No | Yes |
| Tinnitus/ ringing in the ears | No | Yes |
| Vertigo/ dizziness | No | Yes |

## 

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|  |  |  |
| --- | --- | --- |
| Decreased smell | No | Yes |
| Nasal discharge/ drainage | No | Yes |
| Nose bleeds | No | Yes |
| Facial pain | No | Yes |
| Infections | No | Yes |
| Nasal congestion | No | Yes |
| Sneezing | No | Yes |

## HEENT NOSE AND SINUS

|  |  |  |
| --- | --- | --- |
| Headache | No | Yes |
| Eye burning | No | Yes |
| Double vision | No | Yes |
| Eye discharge/ drainage | No | Yes |
| Eye dryness | No | Yes |
| Foreign body sensation | No | Yes |
| Eye itching | No | Yes |
| Rapid eye movements | No | Yes |
| Eye pain | No | Yes |
| Sensitivity to light | No | Yes |
| Eye redness | No | Yes |
| Visual halloes or blind spots | No | Yes |
| Spots/ floaters | No | Yes |
| Tearing | No | Yes |
| Glasses | No | Yes |
| Contacts | No | Yes |
| Visual Loss | No | Yes |

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

|  |  |  |
| --- | --- | --- |
| Cramping in legs when walking | No | Yes |
| Blueing of the hands/ feet | No | Yes |
| Flushing or redness of hands/ feet | No | Yes |
| Cool extremities | No | Yes |
| Swelling of hands, feet or legs | No | Yes |
| Pain in extremities | No | Yes |
| Ulcers in legs, feet and arms | No | Yes |
| Varicose veins | No | Yes |
| Blood clots | No | Yes |

## THROAT AND MOUTH VASCULAR

|  |  |  |
| --- | --- | --- |
| Taste change | No | Yes |
| Voice change | No | Yes |
| Cold sores | No | Yes |
| Difficulty swallowing | No | Yes |
| Hoarseness | No | Yes |
| Lump sensation | No | Yes |
| Pain when swallowing | No | Yes |
| Post nasal drip | No | Yes |
| Sore tongue/ tongue lesions | No | Yes |
| Sore throat | No | Yes |
| Tooth pain/ dentures/ plates | No | Yes |

## 

|  |  |  |
| --- | --- | --- |
| Abdominal mass/ growth | No | Yes |
| Abdominal pain | No | Yes |
| Altered bowel habits- change from normal | No | Yes |
| Not eating or poor appetite | No | Yes |
| Black, tarry stools | No | Yes |
| Bloating and feeling of fullness | No | Yes |
| Blood in stool | No | Yes |
| Constipation | No | Yes |
| Diarrhea | No | Yes |
| Difficult or painful swallowing | No | Yes |

**RESPIRATORY/ THORAX GASTROINTESTINAL**

|  |  |  |
| --- | --- | --- |
| Rapid breathing | No | Yes |
| Cough | No | Yes |
| Chest pain | No | Yes |
| Frequent respiratory infections | No | Yes |
| Coughing up blood | No | Yes |
| Known TB exposure | No | Yes |
| Positive PPD/ TB test | No | Yes |
| Pain with breathing “stitch” | No | Yes |
| Shortness of breath | No | Yes |
| Wheezing | No | Yes |

|  |  |  |
| --- | --- | --- |
| Flatulence/ gas | No | Yes |
| Jaundice/ yellow/ history of hepatitis | No | Yes |
| Indigestion/ heartburn | No | Yes |
| Throwing up blood | No | Yes |
| Nausea | No | Yes |
| Weight loss | No | Yes |
| Hemorrhoids | No | Yes |
| Rectal bleeding | No | Yes |
| Reflux | No | Yes |
| Vomiting | No | Yes |

**CARDIOVASCULAR**

|  |  |  |
| --- | --- | --- |
| Chest pain | No | Yes |
| Shortness of breath at rest | No | Yes |
| Shortness of breath on exertion | No | Yes |
| Sleep sitting up to breathe | No | Yes |
| Shortness of breath at night- causes awakening | No | Yes |
| Swelling of hands and legs | No | Yes |
| Nighttime urination | No | Yes |
| Palpitations/ rapid heart beat | No | Yes |
| Passing out | No | Yes |

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GENITOURINARY WOMEN TO COMPLETE**

|  |  |  |
| --- | --- | --- |
| Back pain/ flank/ side pain | No | Yes |
| Change in urine color/ cloudy urine | No | Yes |
| Urgency to urinate | No | Yes |
| Decreased stream or low urine output | No | Yes |
| Pain when urinating | No | Yes |
| Foul urine odor | No | Yes |
| Urinating frequently | No | Yes |
| Mass in groin | No | Yes |
| Blood in urine | No | Yes |
| Hesitancy or difficulty urinating | No | Yes |
| Urine leakage/ incontinence | No | Yes |

|  |  |  |
| --- | --- | --- |
| Age of first period |  |  |
| Last menstrual period |  |  |
| Frequency of menstrual cycles |  |  |
| Are you post-menopausal? | No | Yes |
| Are you on hormones? | No | Yes |
| Have you previously used hormones? | No | Yes |
| Have you ever used birth control? | No | Yes |
| Have you ever had an abnormal pap? | No | Yes |
| Do you do self breast exams? | No | Yes |
| Lack of libido | No | Yes |
| Nipple discharge | No | Yes |
| Breast lumps | No | Yes |
| Pain with sexual intercourse | No | Yes |
| History of uterine fibroids | No | Yes |
| Problems with infertility | No | Yes |
| Ovarian cysts | No | Yes |
| Sexual dysfunction | No | Yes |
| Vaginal itching | No | Yes |
| Vaginal discharge | No | Yes |

## 

|  |  |  |
| --- | --- | --- |
| History of passing a kidney stone | No | Yes |
| Urgency to urinate | No | Yes |

**METABOLIC/ ENDOCRINE**

|  |  |  |
| --- | --- | --- |
| Voice changes | No | Yes |
| Cold intolerance/ feeling cold | No | Yes |
| Heat intolerance/ feeling hot | No | Yes |
| Hair loss | No | Yes |
| Coarse hair | No | Yes |
| Abnormal glucose/blood sugar tests | No | Yes |
| Abnormal fat distribution | No | Yes |
| Abnormal hair distribution | No | Yes |
| Chronically overweight | No | Yes |
| Chronically underweight | No | Yes |
| Darkening of skin | No | Yes |
| History of gout | No | Yes |
| Excessive perspiration | No | Yes |
| Excessive hunger or thirst | No | Yes |
| Generalized weakness | No | Yes |
| Gestational diabetes | No | Yes |
| Goiter | No | Yes |
| Gynecomastia/ male breast enlargement | No | Yes |
| Low sugar reactions | No | Yes |
| Increase in size of feet/ hands | No | Yes |

|  |  |  |
| --- | --- | --- |
| Are you circumcised? | No | Yes |
| erectile pain | No | Yes |
| Penile discharge | No | Yes |
| Blood in your stream | No | Yes |
| Scrotum/ testicular pain | No | Yes |
| Scrotum/ testicular mass | No | Yes |
| Hydrocele/ fluid around testes | No | Yes |
| History of Herpes Genitalia | No | Yes |
| Problems with fertility | No | Yes |
| Have you ever been treated for a sexually transmitted disease? | No | Yes |
| Describe your sexual function |  |  |
| Normal |  |  |
| Decreased |  |  |

**MEN TO COMPLETE**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NEURO/ PSYCHIATRIC MUSCULOSKELETAL**

|  |  |  |
| --- | --- | --- |
| Language disorder/ Difficulty talking | No | Yes |
| Unclear pronunciation | No | Yes |
| Focal weakness | No | Yes |
| Difficulty walking | No | Yes |
| Headaches | No | Yes |
| Incontinence | No | Yes |
| In-coordination | No | Yes |
| Lightheadedness/ dizziness | No | Yes |
| Loss of consciousness/ fainting | No | Yes |
| Memory loss | No | Yes |
| Tingling/ numbness | No | Yes |
| Seizures | No | Yes |
| Speech changes | No | Yes |
| Tremors | No | Yes |
| Vertigo/ Hx of Meniere’s | No | Yes |
| Visual changes | No | Yes |
| Lack of concentration | No | Yes |
| Do you have any anxiety? | No | Yes |
| Do you feel fearful? | No | Yes |
| Do you feel excessively happy? | No | Yes |
| Do you feel paranoid? | No | Yes |

|  |  |  |
| --- | --- | --- |
| Back pain- neck, mid, low back | No | Yes |
| Bone/ joint swelling or pain | No | Yes |
| Hands/ wrist/ elbow shoulder/ hips/ feet/ ankle swelling or pain | No | Yes |
| Muscle pain/ weakness | No | Yes |

**HEMATOLOGIC**

|  |  |  |
| --- | --- | --- |
| Easy bruising | No | Yes |
| Easy bleeding | No | Yes |
| History of blood clots | No | Yes |
| Anemia or low blood count | No | Yes |
| Swollen lymph nodes | No | Yes |

|  |  |  |
| --- | --- | --- |
| Asthma | No | Yes |
| Hay fever | No | Yes |
| Hives | No | Yes |
| Anaphylaxis | No | Yes |
| Contact dermatitis/ rashes/ metal allergy | No | Yes |
| Food allergies | No | Yes |
| “Bee” sting allergy | No | Yes |
| If yes, reaction type: |  |  |
| Environmental allergies: pollen, pollution | No | Yes |
| Animals at home | No | Yes |
| Animals in the work place | No | Yes |
| Chemicals in the home | No | Yes |
| If yes, type: |  |  |
| Chemicals in the work place | No | Yes |
| If yes, type: |  |  |

**IMMUNOLOGIC**

**DERMATOLOGIC**

|  |  |  |
| --- | --- | --- |
| Acne | No | Yes |
| Contact allergies | No | Yes |
| Hx of excessive sun exposure | No | Yes |
| Frequent skin infections | No | Yes |
| Hair loss | No | Yes |
| Women: facial hair | No | Yes |
| Nail changes (brittle) | No | Yes |
| Change in skin color | No | Yes |
| Severe itching | No | Yes |
| Excessive sweating | No | Yes |
| Sensitivity to light | No | Yes |
| Rash | No | Yes |
| Skin lesions: tags, moles, freckles, birthmarks | No | Yes |