DARLA R. COWART, M.D. KAREN L. ALLEN, M.D. BRIAN A. COST, M.D. JEFF GARRARD, M.D.

Name ______________________ Chart # __________ Date __________

Date of Birth: Mo____/Day____/Yr____ Education (highest completed): __________ Number of Children: ______

Marital Status: ____ Single ____ Married/Committed ____ Separated ____ Divorced ____ Widowed / Widower

Description of Occupation: ______________________

Family Health Problems (i.e., anemia, diabetes, cancer (type?), heart disease, etc.)
Father: ______________________
Mother: ______________________
Siblings: ______________________
Children: ______________________

Allergies / Drug Allergies: ______________________

Hospitalizations & operations (Give dates & reasons):
____
____

Immunizations: Date of last tetanus: ____/____/____ Date of last flu shot: ____/____/____
Date of last pneumonia shot:____/____/____ All usual childhood shots Y/N?______

Social Information: How much do you smoke? __________ How much do you drink? __________
Hobbies: __________ Social Activities: __________
Do you exercise? ______________________
Describe your diet. ______________________
Psychological Health - How are you doing? ______________________
Medications (Please list all medications you use including those not requiring a prescription):
______________________ ______________________ ______________________
______________________ ______________________ ______________________
______________________ ______________________ ______________________

Personal Health Problems (Please check all that apply):

__Abdominal Pain	__Cough	__Blood in Urine	__Rash	__Dizzy Spells
__Loss of Appetite	__Shortness of Breath	__Painful Urinating	__Numbness	__Flushing Spells
__Indigestion	__Hoarseness	__Urinating More	__Bald Spots	__Fainting
__Nausea	__Wheezing	__Breast Problem	__Warts / Moles	__Sweating Spells
__Vomiting	__Irritability	__Loss of Libido	__Athlete's Foot	__Anemia
__Heartburn	__Sleep Problems	__Stiff Joints	__Vision Change	__Seizures
__Diarrhea	__Nervousness	__Back Pain	__Hearing Loss	__Weight Gain
__Constipation	__Tiredness/Fatigue	__Swollen Joints	__Ears Ringing	__Weight Loss
__Gas / Bloating	__Depression	__Irregular Heartbeat	__Tooth Pain	__Vaginal Irritation
__Hemorrhoids	__Anger	__Chest Discomfort	__Gum Pain	__Lightheadedness
__Painful Swallowing	__Memory Loss	__Sinus Problems	__Nose Bleeds	__Swelling in legs
__Blood in Bowels	__High Cholesterol	__Neck Pain	__Headaches	__Swelling in feet

Other: ______________________

Men
__Erection Problems
__Discharge from Penis
__Prostate Problems
__Dribbling Urine after Voiding
__Pain in Scrotum
__Pain in Penis
__Ejaculation Pain

Women
Age when Periods Began: __________ # of Pregnancies; __________
Still menstruating? ________ Yes ________ No
If no, when stopped: ______________________
If yes, length of periods: __________ How often? __________
Date of last period: ____/____/____
Cramping? ______ Heavy Flow? ______________________
____