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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? _____
_____