

NAME:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_DATE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DATE OF BIRTH:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_AGE:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CONFIDENTIAL RECORD: Information contained here will not be released except when you have authorized us to do so:

**NAME/ADDRESS OF PHYSICIAN WHO REFERRED YOU:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PRESENT ILLNESS: Please explain the onset of your present problem. What symptoms you had (location, severity, etc.) What your doctor did to help your and what treatment you have had:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**NAME ANY DRUGS WHICH YOU ARE ALLERGIC TO:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**CIRCLE ILLNESSES YOU HAVE BEEN TREATED FOR IN THE PAST OR ARE BEIGN TREATED FOR NOW:**

**HIGH BLOOD PRESSURE THYROID DISEASE DIABETES ASTHMA HEART FAILURE**

**HEART DISEASE ANEMIA BLOOD CLOTS BLEEDING KIDNEY DISEASE**

**TUBERCULOSIS PNEUMONIA LIVER DISEASE JAUNDICE RHEUMATIC FEVER**

**MENTAL ILLNESS CHICKEN POX SHINGLES STROKE EMPLYSEMA**

**LIST ANY PRIOR HOSPITALIZATIONS OR SURGERIES (GIVE DATE AND REASON FOR EACH):**

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**SOCIAL HISTORY:**

**MARITAL STATUS : (CIRCLE ONE) SINGLE MARRIED DIVORCED SEPARATED WIDOW**

**OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_RELIGION:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU CURRENTLY USE TOBACCO?\_\_\_\_\_\_\_ IN PAST?\_\_\_\_\_\_ DAILY AMOUNT?:\_\_\_\_\_\_ HOW LONG?\_\_\_\_\_\_\_\_\_ QUIT DATE?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ALCOHOL CONSUMPTION?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**HISTORY OF BLOOD TRANSFUSIONS? YES\_\_\_\_\_\_ NO\_\_\_\_\_\_\_\_ WHEN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FAMILY HISTORY: PLEASE LIST ILLNESSES THAT HAVE OCCURRED IN ANYU OF YOUR BLOOD RELATIVES:**

**DIABETES CANCER BLEEDING TENDENCY KIDNEY DISEASE TUBERCULOSIS**

**HEART DISEASE STROKE HIGH BLOOD PRESSURE MENTAL ILLNESS COLON POLYPS**

**ARTHRITIS ANEMA BLOOD CLOTS**

**OTHER:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**REVIEW OF SYMPTOMS: CIRCLE ANY SYMPTOMS YOU ARE CURRENTLY EXPERIENCING:**

**GENERAL: Weakness Fatigue Weight loss/gain Fever Chills Night Sweats Hot Flashes**

**HEENT: Headache Vision Changes Cataracts Decreased hearing Ringing in ears Sinus Congestion**

**Postnasal drip Nosebleed Hay fever Dental Problems Sore throat Hoarseness**

**NECK: Swollen glands Goiter Lumps or masses**

**BREAST: Lumps Pain Nipple discharge Change in self-exam**

**HEART: Chest pain Palpitations Swelling in the legs Shortness of breath lying down**

**LUNGS: Shortness of breath Cough Phlegm Blood in sputum Wheezing History of TB**

**GASTROINTESTINAL: Heartburn Trouble swallowing Change in appitite Abdominal Pain Nausea**

**Vomiting Constipation Diarrhea Dark stools Hemorrhoids Jaundice Hepatitis**

**URINARY: Frequency Urgency Burning with urination Blood in urine Kidney stones Incontinence**

**NEUROLOGIC: Fainting Seizures Numbness/Tingling Localized Weakness Tremors Confusion**

**SKIN: Rash Itching Skin Lesions Nail changes**

**BLOOD VESSELS: Thrombophlebitis Varicose veins Blood clots Easy bruising Abnormal bleeding**

**PSYCHIATRIC: Anxiety Depression Mood Swings Stress/Tension Under Psychiatric care**

**PAIN:\_\_\_YES\_\_\_NO Location:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Severity (Scale 1-10);\_\_\_\_\_\_\_Duration:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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