

ALLERGIES

Please list any drug allergies and the type of reaction you experience with each drug.

Drug	Reaction

REVIEW OF SYMPTOMS

Please check any of the following symptoms that apply to you.

Past	Present	Symptom	Past	Present	Symptom
<input type="checkbox"/>	<input type="checkbox"/>	Weight change (unexpected)	<input type="checkbox"/>	<input type="checkbox"/>	Trouble swallowing
<input type="checkbox"/>	<input type="checkbox"/>	Fever	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn
<input type="checkbox"/>	<input type="checkbox"/>	Chills	<input type="checkbox"/>	<input type="checkbox"/>	Constipation
<input type="checkbox"/>	<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea
<input type="checkbox"/>	<input type="checkbox"/>	Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Blood in stool
<input type="checkbox"/>	<input type="checkbox"/>	Night Sweats	<input type="checkbox"/>	<input type="checkbox"/>	Black, tarry stool
<input type="checkbox"/>	<input type="checkbox"/>	Trouble sleeping	<input type="checkbox"/>	<input type="checkbox"/>	Pencil-thin stool
<input type="checkbox"/>	<input type="checkbox"/>	Appetite change	<input type="checkbox"/>	<input type="checkbox"/>	Hemorrhoids
<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice
<input type="checkbox"/>	<input type="checkbox"/>	Visual change	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting
<input type="checkbox"/>	<input type="checkbox"/>	Hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	Vomiting of blood
<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	Stomach pain which: Occurs after a meal Occurs with eating greasy, fried food Awakens you at night Is relieved by antacids
<input type="checkbox"/>	<input type="checkbox"/>	Ear discharge	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Seasonal / environmental allergies
<input type="checkbox"/>	<input type="checkbox"/>	Sinus problems	<input type="checkbox"/>	<input type="checkbox"/>	Red, itchy eyes
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising
<input type="checkbox"/>	<input type="checkbox"/>	Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	Rash
<input type="checkbox"/>	<input type="checkbox"/>	Sore throat	<input type="checkbox"/>	<input type="checkbox"/>	Change in moles
<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath:	<input type="checkbox"/>	<input type="checkbox"/>	Itchy skin
<input type="checkbox"/>	<input type="checkbox"/>	When doing usual work	<input type="checkbox"/>	<input type="checkbox"/>	Burning when urinating
<input type="checkbox"/>	<input type="checkbox"/>	When climbing one flight of stairs	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine
<input type="checkbox"/>	<input type="checkbox"/>	Which awakens you at night	<input type="checkbox"/>	<input type="checkbox"/>	Frequent urination
<input type="checkbox"/>	<input type="checkbox"/>	Cough	<input type="checkbox"/>	<input type="checkbox"/>	Trouble starting urination
<input type="checkbox"/>	<input type="checkbox"/>	Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>	Trouble holding urine
<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Frequent nighttime urination
<input type="checkbox"/>	<input type="checkbox"/>	Chest pain or tightness:	<input type="checkbox"/>	<input type="checkbox"/>	Muscle pain
<input type="checkbox"/>	<input type="checkbox"/>	When walking fast or up a hill	<input type="checkbox"/>	<input type="checkbox"/>	Joint pain
<input type="checkbox"/>	<input type="checkbox"/>	After a heavy meal	<input type="checkbox"/>	<input type="checkbox"/>	Numbness
<input type="checkbox"/>	<input type="checkbox"/>	When upset or exited	<input type="checkbox"/>	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	<input type="checkbox"/>	That radiates down your arm	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	That disappears when you rest	<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Swelling of ankles	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	
<input type="checkbox"/>	<input type="checkbox"/>	Stress	<input type="checkbox"/>	<input type="checkbox"/>	

IMMUNIZATIONS

Date of last tetanus booster: _____

Date of last pneumonia vaccine: _____

MEN ONLY

Please check any of the following symptoms that apply to you.

Past	Present	Conditions	Past	Present	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Loss of sexual function	<input type="checkbox"/>	<input type="checkbox"/>	Prostate trouble
<input type="checkbox"/>	<input type="checkbox"/>	Discharge from penis	<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease
<input type="checkbox"/>	<input type="checkbox"/>	Lump in testicles	<input type="checkbox"/>	<input type="checkbox"/>	Surgery on private parts

If you are sexually active, do you use condoms? Yes No

WOMEN ONLY

Please check any of the following symptoms that apply to you.

Past	Present	Conditions	Past	Present	Conditions
<input type="checkbox"/>	<input type="checkbox"/>	Bleeding between periods	<input type="checkbox"/>	<input type="checkbox"/>	Abnormal Pap smear
<input type="checkbox"/>	<input type="checkbox"/>	Heavy periods	<input type="checkbox"/>	<input type="checkbox"/>	Breast discharge
<input type="checkbox"/>	<input type="checkbox"/>	Extreme menstrual pain	<input type="checkbox"/>	<input type="checkbox"/>	Breast lump
<input type="checkbox"/>	<input type="checkbox"/>	Unusual vaginal discharge	<input type="checkbox"/>	<input type="checkbox"/>	Painful intercourse
<input type="checkbox"/>	<input type="checkbox"/>	Sexually transmitted disease	<input type="checkbox"/>	<input type="checkbox"/>	Hot flashes

Menstrual History		Obstetric History	
Date of last menstrual period:	_____	Number of times you've been pregnant:	_____
Age at first period:	_____	Number of children born alive:	_____
Length of periods:	_____	Number of children born dead:	_____
Number of days between periods:	_____	Number of miscarriages:	_____
Age when periods stopped:	_____	Number of Caesarean sections:	_____
		Complications of pregnancy:	_____
Date of last Pap smear:	_____	Date of last mammogram:	_____
Was it normal? Yes No		Was it normal? Yes No	

If you are sexually active, do you use birth control? Yes No If yes, what type? _____