

Last Name: _____ First Name: _____ M.I.: _____ Age: _____
 Family Physician: _____ Sports: _____
 Cardiologist: _____
 Reason for Appointment: _____

Injuries: Have you ever had in the past?
 Broken Bones/Fractures Yes No
 Knee Injuries Yes No
 Sprains or Joint Dislocations Yes No
 Extensive Lacerations Yes No
 Concussion/Head Injury Yes No

Habits: Do you?
 Sleep Well Yes No
 Use Alcoholic Beverages Yes No
 Everyday Yes No
 Smoke Yes No
 How Much _____ Pks

Hospitalizations:

Previous Surgical Procedures:
 1) _____
 2) _____
 3) _____

Previous Hospitalizations/Illness:
 1) _____
 2) _____
 3) _____

Illness: Have you ever had in the past or presently have?

Migraine Headaches Yes No
 Hepatitis Yes No
 Urine Infection Yes No
 Venereal Disease Yes No
 Arthritis Yes No
 Asthma Yes No
 Angina/Heart Problems Yes No
 Rheumatic Fever Yes No
 Frequent infections Yes No

Ulcers Yes No
 Gallbladder Disease Yes No
 Seizures/Convulsions Yes No
 Meningitis or Polio Yes No
 Pneumonia Yes No
 Tuberculosis Yes No
 Thyroid Disease Yes No
 High Blood Pressure Yes No
 Diabetes Yes No
 Other Major Disease Yes No

Explain: _____
 What? _____

Allergies:

Are you allergic to any medications? Yes No

Medications: List any medications and dosage that you are taking

1) _____ 3) _____
 2) _____ 4) _____

Family History: Has any blood relative ever had: (Indicate M-Mother, F-Father, B-Brother, S-Sister)

____ Cancer ____ Tuberculosis ____ Diabetes ____ Heart Trouble ____ High Blood Pressure
 ____ Epilepsy ____ Suicide ____ Mental Illness ____ Birth Defects ____ Alcoholism ____ Stroke

Please Check if you Now have or have Recently had any of the following symptoms:

- General:** fever, unexplained weight loss, night sweats, unusual fatigue
- Neurological:** headaches, paralysis, numbness, speech problems, double vision, blurred vision, fainting, falling
- Eyes:** blindness, cataract, glaucoma, sudden loss of vision in one eye
- Ears:** decreased hearing, infection, dizziness, vertigo
- Throat:** swallowing difficulty, pain with chewing
- Heart:** chest pain, palpitations
- Lungs:** shortness of breath, persistent cough, blood in sputum
- G-I:** diarrhea, constipation, nausea, vomiting, bloody or tarry black stools
- Hematologic:** unusual bleeding, easy bleeding
- G-U:** difficulty urination with, hesitancy, urgency, burning, incontinence
- Psychiatric:** depression, severe anxiety, hallucinations
- Skin:** rash, skin cancer
- Musculoskeletal:** joint pain, swelling, locking, catching, buckling, giving away, redness, warmth, stiffness, muscle cramps, night pain (waking from sleep)

Have you or anyone in your family ever filed a medical malpractice claim? Yes No

Patient Signature: _____ Date: _____