Family History (cont.)
(Circle "no" or "yes", leave blank if uncertain)

			Relationship
Asthma	no	yes	
Chronic lung disease	no	yes	
Drug or alcohol problem	no	yes	
Mental Illness	no	yes	
Leukemia	no	yes	
Migraine headaches	no	yes	
Obesity	no	yes	
Thyroid Disease	no	yes	
Ulcer	no	yes	
Depression	no	yes	
High Cholesterol	no	yes	
Kidney Disease	no	yes	
Glaucoma	no	yes	
Gout	no	yes	

	Present age, or age of death	If living, health (good, fair, poor) If deceased, cause of death
Father		
Mother		
Siblings		
Spouse		
Children		

Do you have now or have you had within the past year: (Circle "no" or "yes", leave blank if uncertain)

Weakness or paralysis	no	yes
Tire easily or weakness	no	yes
Recent weight changes	no	yes
Change in appetite	no	yes
Sensitivity to cold or heat	no	yes
Persistent fever	no	yes
Night sweats or hot flashes	no	yes
Skin rash	no	yes
Skin trouble or changes	no	yes
Change in nails or hair	no	yes
Headaches	no	yes
Easy bleeding or bruising	no	yes
Double vision	no	yes
Blurred vision	no	yes
Eye pain	no	yes
Infected eyes	no	yes
Do you wear glasses or contacts	no	yes
When was your last eye exam ______		
Ringing in the ears	no	yes
Discharge from ears	no	yes
Ear pain	no	yes
Decrease in hearing	no	yes
Frequent nosebleeds	no	yes
Frequent colds	no	yes
Sinus trouble	no	yes
Loss of smell	no	yes
Persistent hoarseness	no	yes
Sore throat	no	yes
Sore tongue or gums	no	yes
Lump or discharge from breast	no	yes
A persistent cough or throat clearing not associated with a known illness (lasting more than 3 weeks)	no	yes

Shortness of breath	no	yes
Bloody sputum	no	yes
Wheezing	no	yes
Chest pain or discomfort	no	yes
Purple fingers or lips	no	yes
Swelling of hands, feet or ankles	no	yes
Difficulty in breathing	no	yes
Palpitations or fluttering of the heart	no	yes
Leg cramps on walking or at night	no	yes
Enlarged veins	no	yes
Difficulty swallowing	no	yes
Heartburn	no	yes
Frequent belching	no	yes
Abdominal cramping	no	yes
Nausea	no	yes
Vomiting	no	yes
Vomited or coughed up blood	no	yes
Chronic diarrhea	no	yes
Chronic constipation	no	yes
Rectal bleeding	no	yes
Black tarry stools	no	yes
Dark urine	no	yes
Yellow jaundice	no	yes
Frequent urination (day)	no	yes
Frequent urination (night)	no	yes
Increase in thirst	no	yes
Painful urination	no	yes
Leakage of urine	no	yes
Difficulty in starting urine	no	yes
Blood in urine	no	yes
Lack of sex drive	no	yes
Hemorrhoids	no	yes
Backaches	no	yes

Joint pain or stiffness	no	yes
Swollen joints	no	yes
Muscle cramps or spasms	no	yes
Sleeplessness	no	yes
Seizures	no	yes
Depression	no	yes
Memory loss	no	yes
Poor coordination	no	yes
Dizziness or fainting spells	no	yes
A living will or advance directive	no	yes
Men only:		
Discharge from penis	no	yes
Pain or lump in testicles	no	yes
Impotence	no	yes
Women only:		
Age period began ______		
How many days do periods last? ______		
How many days between periods? ______		
Is the flow heavy?	no	yes
Do you bleed or spot between periods?	no	yes
Do you have pain or cramps?	no	yes
Date of last period? ______		
Date of last pelvic exam? ______		
Date of last mammogram? ______		
Any itching in vaginal area?	no	yes
Pain with intercourse?	no	yes
Type of birth control used? ______		
Number of pregnancies ______		
Number of full term births ______		
Number of preterm births ______		

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my (my child's) health. It is my responsibility to inform the doctor's office of any changes in my (my child's) medical status. I also authorize the healthcare staff to perform the necessary health care services I (my child) may need.

X ______________________________ Signature of patient or parent if minor

______________________ Date

Physician's Comment

Physician's Signature ______________________________