



ADVANCED SPECIALTY CARE

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GENERAL HEALTH HISTORY

Patient Name: _____

Date: _____

Date of Birth: _____

Age: _____

Sex: M F

MEDICAL HISTORY: Please check any items that you currently have a diagnosis for or have had in the past:

- | | | |
|---|---|--|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cirrhosis | <input type="checkbox"/> Irritable bowel syndrome |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Congestive heart failure | <input type="checkbox"/> Kidney stones |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Depression | <input type="checkbox"/> Mitral valve prolapse |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Autoimmune disease | <input type="checkbox"/> Diverticulitis | <input type="checkbox"/> Peptic ulcer disease |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Peripheral vascular disease |
| <input type="checkbox"/> Blood clot in lung or legs | <input type="checkbox"/> GERD | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Blood transfusions | <input type="checkbox"/> Gout | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Bowel disorder | <input type="checkbox"/> Headaches | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Benign breast disease | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Cancer of _____ | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Urinary Incontinence |
| <input type="checkbox"/> Cardiac disease | <input type="checkbox"/> Irregular heart | <input type="checkbox"/> Varicose Veins |

SURGICAL HISTORY: Please list all surgeries you have had and the approximate dates:

Last Hospitalization: When? _____ What for? _____

Date of Last Rectal Exam/Colonoscopy: _____

ALLERGIES:

To medications: _____

To food: _____

To other substances such as latex, adhesive tape, metal, iodine, etc: _____

FAMILY HISTORY:

	<u>Alive</u>	<u>Deceased</u>	<u>Age</u>	<u>Healthy</u>		<u>Medical Illness</u>
Father	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Paternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Paternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Mother	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Maternal Grandmother	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Maternal Grandfather	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Sisters	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____
Brothers	<input type="checkbox"/>	<input type="checkbox"/>	_____	<input type="checkbox"/> Y	<input type="checkbox"/> N	_____

SOCIAL HISTORY: Please answer the following as honestly as possible:

Do you smoke? Y N What and how much per day? _____

If not, have you ever smoked? Y N When did you quit? _____

OVER →

Have you ever used recreational drugs (i.e. Marijuana, Methamphetamines, Cocaine, or Heroin)? Y N
 What and for how long? _____
 Do you exercise regularly? Y N How often? _____
 Do you drink alcohol? Y N What and how much? _____
 What is your occupation? _____
 Have you traveled outside the United States recently? Y N If so, where? _____

REVIEW OF SYSTEMS: Please check all symptoms that apply now **or** in the past.

Constitutional:

- Weight gain
- Weight loss
- Loss of appetite
- Fever
- Weakness
- Night sweats

Dermatology:

- Rash
- Change in color of moles
- Lumps
- Dry or sensitive skin
- Hives

Endocrinology:

- Fatigue
- Excessive sweating
- Excessive thirst
- Excessive urination
- Cold intolerance
- Heat intolerance

Neurology:

- Headache
- Tingling or numbness
- Seizures
- Insomnia
- Memory loss
- Dizziness

Ophthalmology:

- Diminished vision
- Eye irritation
- Drainage from the eyes
- Blurring of vision
- Seasonal eye irritation

Hematology/Lymph:

- Swollen glands
- Varicose veins
- Easy bruising

Urology:

- Difficulty urinating
- Blood in urine
- Urinary urgency
- Frequent urination
- Urinary incontinence
- Voiding dysfunction
- Painful intercourse
- Recurrent urinary tract infection
- Frequent urination at night

ENT:

- Cold
- Cough
- Coughing blood
- Nosebleeds
- Hearing loss
- Change in voice
- Sore throat
- Ringing in ears
- Snoring

Cardiology:

- Chest pain with exertion
- Palpitations
- Leg and ankle swelling
- Shortness of breath
- Difficulty breathing at night

Musculoskeletal:

- Joint swelling
- Joint pain
- Leg cramps
- Joint stiffness
- Muscle pain

Psychology:

- High stress level
- Depression
- Sleep disturbances
- Suicidal ideation
- Eating disorder
- Mental or physical abuse
- Schizophrenia

Gastroenterology:

- Nausea
- Heartburn
- Fecal incontinence
- Vomiting
- Bloating/belching
- Jaundice
- Difficulty swallowing
- Abdominal pain
- Diarrhea
- Constipation
- Change in bowel habits
- Blood in stool

Allergy:

- Runny nose
- Scratchy throat
- Itchy eyes
- Ear fullness or congestion
- Sinus congestion
- Stuffy nose

Female Reproductive: (for females only)

- | | | |
|--|--|---|
| <input type="checkbox"/> Heavy periods | <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Premenstrual syndrome |
| <input type="checkbox"/> Dysmenorrhea | <input type="checkbox"/> Infertility | <input type="checkbox"/> Frequent yeast infections |
| <input type="checkbox"/> Vaginal itching | <input type="checkbox"/> Vaginal spotting | <input type="checkbox"/> Postmenopausal bleeding |
| <input type="checkbox"/> Pelvic pain | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Abnormal vaginal discharge |
| <input type="checkbox"/> Hot flashes | | |

Last Mammogram _____ Last Pap Smear _____

Male Reproductive: (for males only)

- | | | |
|---|--|---|
| <input type="checkbox"/> Difficulty with erection | <input type="checkbox"/> Difficulty with ejaculation | <input type="checkbox"/> Diminished sex drive |
|---|--|---|

