Date ____________________

Name ____________________ Age __________ Single Married Divorced Widow(er)

Occupation ____________________

Birth Place ____________________ Birthdate ____________________

Education __________ Years Highschool __________ Years College

FAMILY HISTORY

	Age	If Living Health	If Deceased Age at Death	Cause	Has any blood relative ever had	No or Yes	Please Circle Who
Father					Cancer	No or Yes	
Mother					Tuberculosis	No or Yes	
Brothers or					Diabetes	No or Yes	
Sisters					Heart Trouble	No or Yes	
					High Blood Pressure	No or Yes	
					Stroke	No or Yes	
					Epilepsy	No or Yes	
Husband or Wife					Insanity	No or Yes	
Sons or Daughters							

NOTE: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

PERSONAL HISTORY: Please check ALL that applies		
ILLNESSES: Have you ever had	Have you ever been advised to have any	***NEUROLOGIC: Have you ever***
Measles	surgical operation which has not	Fainted or been knocked out
German Measles	been done No or Yes	Had numbness or tingling of arms,
Mumps	Have you been hospitalized for	legs or one side of body
Chicken Pox	any illness No or Yes	Had seizures or convulsions
Whooping Cough	Give Details:	Had a tremor
Scarlet Fever or Scarlentina		Been depressed
Diphtheria		Been treated for mental illness
Smallpox		Had unusual mood swings
Rheumatic fever or heart disease		Had a stroke
Polio or Meningitis		Had a warning of stroke or TIA
Gonorrhea or Syphilis	***GENERAL: Do you:***	***HEAD:***
Tuberculosis	Smoke ______ Packs per day ____ .	Do you have headaches
ALLERGIES: Are you allergic to	Pipe ________ Years __________ .	Have you ever been injured
Penicillin or Sulfa	Cigars ______ Quit __________ .	in the head No or Yes
Aspirin, Codeine or Morphine	Use Alcohol	***EYES: Do you***
Mycins or other Antibiotics	How much ______________ .	Wear glasses or contacts
Merthiolate or Mercurochrome	Exercise regularly	Have pain in the eyes
Any other drug	Feel tired or run down	Blurry vision
Any foods	Have problems sleeping	Double vision
Adhesive tape	Have you ever had a	Have glaucoma
nail polish or other cosmetics	Blood transfusion	Have cataracts
Tetanus Antitoxin or Serums	***SKIN:***	Have flashing lights in front
SURGERY: Have you had	Any skin problems	of eyes or black
Tonsillectomy	Itching or burning	Have momentary or temporary
Appendectomy	Rash	blindness
Any other operation	Eczema or Hives	Have eye pain
Type Date	Varicose veins	Name of eye doctor
Type Date	Change in hair	
Type Date	Problems with toe or fingernails	Date last checked

EARS: Do you have	Chest pain, tightness, discomfort	Dry skin
Pain in ears	Palpitations or skip beats	Any diabetes in family
Ringing, roaring or tinnitus	Swelling of hands or feet	Any thyroid problems or goiter in
Discharge	Do you wake up at night short	family
Infections	of breath	***MUSCULOSKELETAL:***
Hearing problems	Use more than 1 pillow	Any broken bones
Balance problems	Get out of breath going uphill	which bones
NOSE: Do you have	Up stairs	
Sinus problems	On level ground	Arthritis
Nose Bleeds	Do you have angina	Which joints
Loss of smell	Have you ever been told you had	
MOUTH: Do you have	a heart attack	Do your joints get red, hot, swollen
Dentures	Do you get leg cramps	Any back pain or problems
Sores in mouth	***GASTRONINTESTINAL:***	***MEN ONLY: Do you have***
Name of Dentist	Appetite Good Poor	Prostate problems
	Do you have aor have ever had	Weak or slow urine
NECK: Do yu have	a change in weight	Burning or discharge from penis
Unusual lumps or bumps	Trouble swallowing	Swelling or lumps in testicles
Arthritis	Heartburn or indigestion	Hernia or rupture
Goiter or thyroid problems	Ulcers	Difficulty getting or maintaining
Blood: Do you	Hepatitis or yellow jaundice	an erection
Bruise easily	Problems with nausea and	***WOMEN ONLY:***
Have bleeding problems	vomiting	Age when periods started
Have anemia or low blood	Problems with fried food or	Age when periods stopped
Any blood diseases	fatty food	Date of last period
RESPIRATORY: Have you ever	Gallbladder problems	Date of last pap smear
Had bronchitis or pneumonia	Any problems with bowel movement	Periods Regular Irregular
Had weezing, asthma, hay fever		Usually painful Heavy
Coughed up blood	How often do bowels move	Any vaginal bleeding between
Been told you hav emphysema	Use laxatives	periods
Worked around:	Bleeding in bowels	Vaginal discharge
Asbestos	Vomiting blood	Pain in pelvis
Silica dust and sand	Hemorrhoids	Do you now use or did you ever use
Coal dust	Problems with diarrhea	IUD
Toxic chemicals	***GENITOURINARY: Have you ever had***	Birth control pills
Had a chest x-ray	Bladder or kidney infections	Pregnancies:
When	Passed blood	How many
Had pleurisy	Passed a stone	How many stillbirths
Had night sweats	Lose control of urine with cough,	How many premature
Have a chronic cough	sneeze, exercise	How many miscarriges
Cough up phlegm	Do you get up at night to urinate	Any complications
Do you get shor of breath	How often	Do you have
When	***ENDOCRINE: Do you have***	Brest lumps
CARDIAC: Do you have	Excess thirst or urination	Breast pain
High blood pressure	Inability to withstand hear or	Breast discharge
Any heart problems	cold	Any relative with breast cancer
A heart murmur	Change in texture of hair	

COMMENTS:

Name____Date________________________

Previous Health Care Providers in the past five years:

Name City/State Problem cared for: Still seeing? Referral?

____Yes/No Yes/No

____Yes/No Yes/No

____Yes/No Yes/No

____Yes/No Yes/No

Allergic and Adverse Reactions to Medications:

Name of Medication: Adverse Reaction:

____

____

____

Additional Information:

Last Mammogram_______________Where____

Last Pap________________Gyn_________________________Dr. Harman to perform future paps Yes/No

Last Colonoscopy__________Normal__________Dr____________________Repeat date__________

Last Bone Density__________________________

Approximate date of last blood work______________________________Rectal Exam_______________

Vaccine Dates:

Tetanus___________Pneumonia______________Flu______________Hepatitis B Series_______________

Shingles Vaccine___________________________