



**Occupation:** \_\_\_\_\_ **Children:** Yes \_\_\_ No \_\_\_ How many? \_\_\_\_\_

**Marital Status:** Single \_\_\_\_\_ Married \_\_\_\_\_ Divorced \_\_\_\_\_ Other \_\_\_\_\_

**Do you live with:** Spouse \_\_\_ Partner \_\_\_ Friends \_\_\_ Parents \_\_\_ Alone \_\_\_ Children \_\_\_

**Childhood immunizations and vaccines**

Polio	Yes	No	Diphtheria	Yes	No	Tetanus shot	Yes	No
Pertussis	Yes	No	Measles/Mumps/Rubella	Yes	No	Other	Yes	No

**Childhood illnesses**

Scarlet Fever	Yes	No	Diphtheria	Yes	No	Rheumatic Fever	Yes	No
Mumps	Yes	No	Measles	Yes	No	German Measles	Yes	No
Other	_____							

What Hospitalizations and Surgeries have you had? \_\_\_\_\_  
\_\_\_\_\_

How many X-Ray, CAT, MRI, Ultrasound, Electrocardiogram, Electroencephalogram have you had?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Allergies**

Do you have any reaction to foods, drugs or other allergens in your environment (cats, mold, dust)?  
Yes \_\_\_ No \_\_\_ If yes, please explain. \_\_\_\_\_  
\_\_\_\_\_

**Current Medications** (Circle the medications that you take):

Pain relievers (aspirin or Tylenol)	Cortisone (cream or pills)	Thyroid medication	Sleeping Pills
Diet Pills/Appetite suppressants	Antacids (Rolaids or Tums)	Tranquilizers	

Please list any prescription medications, over-the-counter drugs, vitamins, minerals, herbs and other supplements that you are taking at this time and how much of these with doses.

- |          |          |          |
|----------|----------|----------|
| 1) _____ | 4) _____ | 7) _____ |
| 2) _____ | 5) _____ | 8) _____ |
| 3) _____ | 6) _____ | 9) _____ |



**FEMALE REPRODUCTIVE**

Age menses began \_\_\_\_\_  
 Average number of days \_\_\_\_\_  
 Length of cycle \_\_\_\_\_  
 Bleeding between periods **C P N**  
 Are cycles regular **C P N**  
 Painful menses **C P N**  
 Painful during intercourse **C P N**  
 Excessive flow **C P N**  
 Birth control? Yes No  
 What type? \_\_\_\_\_  
 Number of pregnancies \_\_\_\_\_  
 Number of live births \_\_\_\_\_  
 Number of miscarriages \_\_\_\_\_  
 Number of abortions \_\_\_\_\_  
 Difficulty conceiving? Yes No  
 Menopausal symptoms **C P N**  
 Are you sexually active? Yes No  
 Sexual difficulties **C P N**  
 Venereal disease **C P N**  
 Sexual preference:  
 Heterosexual \_\_\_\_\_  
 Bisexual \_\_\_\_\_  
 Homosexual \_\_\_\_\_  
 Do you do self-exam? **C P N**  
 Lumps **C P N**  
 Pain or tenderness **C P N**  
 Nipple discharge **C P N**

**MALE REPRODUCTIVE**

Hernias **C P N**  
 Testicular mass **C P N**  
 Testicular pain **C P N**  
 Are you sexually active? Yes No  
 Sexual difficulties **C P N**  
 Prostate disease **C P N**  
 Venereal disease **C P N**  
 Discharges or sores **C P N**  
 Sexual preference:  
 Heterosexual \_\_\_\_\_  
 Bisexual \_\_\_\_\_  
 Homosexual \_\_\_\_\_

**MUSCULOSKELETAL**

Joint pain or stiffness **C P N**  
 Arthritis **C P N**  
 Broken bones **C P N**  
 Muscle spasms or cramps **C P N**  
 Weakness **C P N**

**PERIPHERAL VASCULAR**

Deep leg pain **C P N**  
 Thrombophlebitis **C P N**  
 Cold hands/feet **C P N**  
 Varicose veins **C P N**

**NEUROLOGIC**

Fainting **C P N**  
 Seizures **C P N**  
 Loss of memory **C P N**  
 Paralysis **C P N**  
 Muscle weakness **C P N**  
 Numbness or tingling **C P N**

**EMOTIONAL**

Depression **C P N**  
 Mood swings **C P N**  
 Anxiety or nervousness **C P N**  
 Tension **C P N**

**ENDOCRINE**

Hypothyroid **C P N**  
 Heat or cold intolerance **C P N**  
 Excessive thirst **C P N**  
 Excessive hunger **C P N**

**BLOOD**

Anemia **C P N**  
 Easy bleeding or bruising **C P N**

What are your main interests and hobbies?

\_\_\_\_\_  
 \_\_\_\_\_

Do you exercise? Yes No

What type of exercise do you do?  
 \_\_\_\_\_  
 \_\_\_\_\_

How many days a week (0-7)? \_\_\_\_\_

Do you eat three meals a day? Yes No

Sleep well? Yes No

Average 6-8 hrs sleep? Yes No

Enjoy your work? Yes No

Spend time outside? Yes No

Watch television? Yes No

How many hours a day? \_\_\_\_\_

Read?

How many hours a day? \_\_\_\_\_

Take vacations? Yes No

Have you been treated for drug dependence?  
 Yes No

Use recreational drugs? Yes No

Use alcoholic beverages? Yes No

Have you been treated for alcoholism?  
 Yes No

Use tobacco Yes No