Please take time to complete this questionnaire. The information is strictly confidential and will help us for a comprehensive assessment of your health care needs. Thank you.

Immunizations and Preventive Services: Check all that apply and provide the dates

❑ MMR	❑ Pneumonia vaccine	❑ TB skin test	❑ Eye exam	❑ PAP smear	❑ Bone density test
❑ Tetanus	❑ Hepatitis B vaccine	❑ Hearing test	❑ Colon exam	❑ Mammogram	❑ PSA

Major Surgeries and Year:

	❑ Brain surgery	❑ Others:
	❑ Abdominal surgery	
❑ Open heart surgery	❑ Pelvic surgery	
❑ Artificial heart valves	❑ Head and neck surgery	
❑ Joint replacement surgery	❑ Vascular surgery	

Medical Illnesses or Conditions:		❑ Bronchitis	❑ Liver diseases
❑ Strokes	❑ Carotid blockage	❑ Sinusitis	❑ Pancreatitis
❑ Aneurysm	❑ Arterial blockage	❑ Ear infections	❑ Hemorrhoids
❑ Dementia	❑ Venous blockage	❑ Sore throat	❑ Arthritis
❑ Parkinson	❑ Arterial aneurysm	❑ Ear pains	❑ Gout
❑ Chest pain	❑ COPD	❑ Trouble swallowing	❑ Back pains
❑ Irregular heart beats	❑ Trouble breathing	❑ Hoarseness	❑ Thyroid disease
❑ Heart attacks	❑ Asthma	❑ Gastric ulcers	❑ Diabetes
❑ Heart failure	❑ Pneumonia	❑ Heartburn	❑ Sexual dysfunction
❑ Heart valve leaks	❑ Lung collapse	❑ Esophageal diseases	❑ Prostate diseases
❑ High blood pressure	❑ Pleural effusions	❑ Bowel diseases	❑ Incontinence
❑ Lung cancer	❑ Lymphoma	❑ Blood clots	❑ Syphilis
❑ Colon cancer	❑ Leukemia	❑ Kidney diseases	❑ Skin diseases
❑ Breast cancer	❑ Anemia	❑ Mental illnesses	❑ Erectile dysfunction
❑ Prostate cancer	❑ Bleeding problems	❑ HIV	❑ Lupus

❑ Other Conditions:

Allergies:

Family History: Please check conditions identified in your relatives and note the affected relatives

❑ Heart disease	❑ Lung diseases	❑ Ovarian cancer
❑ High blood pressure	❑ Kidney diseases	❑ Thyroid diseases
❑ Diabetes	❑ Colon cancer	❑ Bleeding problems
❑ Liver diseases	❑ Breast cancer	❑ Blood clots
❑ Strokes	❑ Mental illness	❑ Dementia

Other conditions:

Social and Personal History			
Education:		Marital status:	
Occupation:			
Tobacco use:			
Alcohol use:			
Recreation substance use:			
Exercise:		Always wear seatbelt?	
Sexual history:	❑ Multiple partners	❑ Opposite-sex relationships	❑ Same-sex relationships

Name DOB SSN

Review of Systems: Please check any item which describes recent or ongoing symptoms

General: ❑ Weight loss ❑ Loss of feeling of well-being ❑ Fatigue or loss of energy
❑ Difficulty sleeping ❑ Fever

Eyes: ❑ Blurred vision ❑ Double vision ❑ Spots in front of eyes
❑ Corrective lenses ❑ Eye pain or irritation

Ear, Nose and Throat: ❑ Chronic headaches ❑ Hearing loss ❑ Ringing in ears
❑ Chronic nasal congestion ❑ Recurring sinus infections ❑ Nose bleeds
❑ Nasal obstruction ❑ Bleeding gums ❑ Sore throat ❑ Toothaches
❑ Breath odor ❑ Hoarseness

Respiratory: ❑ Shortness of breath ❑ Cough ❑ Chest congestion
❑ Wheezing ❑ Cough up blood ❑ Choking
❑ Noisy breathing ❑ History of pneumonia ❑ History of tuberculosis

Cardiovascular: ❑ Chest pain ❑ Heart fluttering or racing Heart murmur
❑ Leg swelling ❑ Irregular heart beats Fainting spells
❑ Awakening due to shortness of breath ❑ Difficulty breathing when lying down ❑ Unhealed leg/foot ulcers
❑ Sensitivity of hands or feet to temperature changes ❑ Pain in buttocks or legs with exercise

Breasts: ❑ Breast lumps ❑ Breast pain ❑ Nipple discharge
❑ Skin redness ❑ Skin thickening

Gastrointestinal: ❑ Stomach pains ❑ Nausea ❑ Vomiting
❑ Diarrhea ❑ Constipation ❑ Heartburn
❑ Indigestion ❑ Belching/Sour taste ❑ Bloating ❑ Abdominal pain
❑ Difficulty swallowing ❑ History of hepatitis ❑ History of yellow jaundice ❑ Rectal bleed
❑ Rectal pain/irritation ❑ Swelling or hemorrhoids

Genitourinary (Men): ❑ Frequent urination ❑ Frequent urge to pee ❑ Pain on urination
❑ Bloody urine ❑ Penile discharge ❑ Trouble start urination
❑ Interruption of stream ❑ Dribbling ❑ Loss of bladder control ❑ Pain or swelling of penis
❑ Pain/swelling of scrotum ❑ Pain/swelling in groin ❑ Decline in sex desire ❑ Difficulty having erection

Genitourinary (Women): ❑ Frequent urination ❑ Frequent urge to pee ❑ Pain on urination
❑ Bloody urine ❑ Frequent urinary infection ❑ Pressure in vagina
❑ Vaginal wall protrusion ❑ Frequent loss of urine ❑ Vaginal discharge ❑ Vaginal irritation
❑ Vaginal redness ❑ Vaginal pain ❑ Painful intercourse ❑ Decline in sexual desire
❑ Difficulty in sexual response ❑ Hot flashes ❑ Change in periods ❑ Painful periods
❑ Discomfort before periods ❑ Other pelvic pain
Please indicate: Last menstrual period:
Number of pregnancies: Number of deliveries: Number of miscarriage /Abortions:
Age at onset of periods: Periods occur every _____ Days and last _____ Days

Lymphatic / Hematologic: ❑ Unusual lymph nodes ❑ Painful lymph nodes ❑ History of anemia
❑ Blood clots ❑ Bruise easily ❑ Unusual bleeding

Musculoskeletal: ❑ Limb/joint pain ❑ Limb or joint deformity ❑ Limb or joint swelling
❑ Joint stiffness or redness ❑ Muscle weakness ❑ Loss of muscle mass
❑ Muscle spasms ❑ Recurring back/neck pain ❑ Back/Neck injury

Neurological: ❑ Seizures ❑ Tremors or shakiness ❑ Unusual clumsiness
❑ Limb weakness ❑ Numbness or tingling ❑ Stroke
❑ History of head injury ❑ Altered consciousness ❑ Black outs ❑ Severe headaches

Psychologic: ❑ Lapses in memory ❑ Mood swings ❑ Difficulty concentrating
❑ Troublesome depression ❑ Worry about things ❑ Confusion or disorientation
❑ History of mental illness ❑ Unusual stress ❑ History of mental or physical abuse

Endocrine: ❑ Intolerance to heat ❑ Intolerance to cold ❑ Unusual thirst
❑ Breast changes ❑ Milky discharge from nipples ❑ Change in hair
❑ Change in sexual characters ❑ Rapid weight gain ❑ Change in menstrual periods

Allergy / Immunologic: ❑ Seasonal allergies ❑ Sensitive to specific items
❑ Frequent unusual infections

Skin: ❑ Itching ❑ Rash ❑ Unusual dryness
❑ Changes in hair ❑ Changes in pigmentation ❑

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