

Medical History

Today's Date: _____ Sex: ____M ____F

Name: _____ Date of Birth: _____

Allergies to Medication, X-Ray Dyes, or other substances: ____ YES ____ NO

Past Medical History: Please CIRCLE if YOU have had problems with or are presently complaining of any of the following:

Abdominal pain	Acid reflex disease	Allergic rhinitis/Hay fever
Anemia	Antibiotics for dental work	Anxiety
Arthritis-degenerated	Arthritis-rheumatoid	Asthma
Blood in stool	Constipation-chronic	COPD/emphysema
Coronary artery disease	Depression	Diabetes type I or II
Diarrhea-chronic	Gall bladder disease	Gout
Headache/Migraine	Headache-chronic	Heart attack/chest pain
Hemorrhoids	Hepatitis	High blood pressure
High cholesterol	Kidney stone	other: _____
Positive TB skin test	Seizure	_____
Stomach ulcer	Urinary tract infection	_____
Low back pain	Shin lesions	_____

Please list and supply the dates of:

Operations: _____

Hospitalizations other than for surgery: _____

Immunization history - Have you had: Pneumonia ____ No, ____ Yes, When? _____

Hepatitis B? ____ No, ____ Yes When? _____ Flu ____ No, ____ Yes, When? _____

Other? ____ No, ____ Yes When? _____ Tetanus? ____ No, ____ Yes, When? _____

When was your last: Last Complete Physical Exam _____

Eye Exam _____ Cholesterol Check _____ Stool check for blood _____

Male Only: Prostate Exam _____ or NEVER _____

Female Only: Mammogram _____ or NEVER _____, Breast Exam _____ or NEVER _____, PAP Smear _____ or NEVER _____, Last Period _____.

Any abnormal reports: _____

Medications that you take, (prescription, over the counter, vitamins, herbs, etc).

Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Family History: Has any member of your family (parents, grandparents, & siblings) ever had the following?

ILLNESS

WHICH FAMILY MEMBER

Cancer (type) _____

High blood pressure _____

Heart attack/Angina _____

Diabetes Type I or II _____

Stroke _____

Mental disease _____

(Anxiety, depression, etc.)

Drug/alcohol abuse _____

High Cholesterol _____

Other:

Prevention:

Smoke or use tobacco? Never, Packs per Day for Yrs. Quit how Long, Yrs.

Use drugs? Never, Remote h/o, IV Drugs, Non IV Drugs,

(Marijuana, cocaine, crack, etc.)

Drink alcoholic beverages? Never, Rarely, Socially, Past h/o abuse, Occasional

Exercise? Regularly, Occasional, Rarely, Never

Ever worked or been exposed to Asbestos, Hepatitis, Tuberculosis, Toxic chemicals

Own any guns? No, Yes If yes, are they locked or unsecured?

Wear seatbelts? Always, Usually, Never

Ever engaged in any activity that has put you at risk of getting AIDS? No, Yes,

If yes, explain: _____

Wish to be tested for AIDS? No, Yes.

Social History:

Have a history of being abused? No, Yes

What is your highest level of education? Elementary School, Middle School, High school

College, Graduate, Currently in school, None

OTHER: _____

Have any children? No Yes How many? _____

Would you say in general, compared to other people your age that your health is:

Excellent, Very good, Good, Fair, Poor?

Circle any of the following problems that may have affected you recently.

General: weight gain, weight loss, weakness, fever, night sweats, HIV, feeling of tiredness.

Skin: bald, change in skin lesions, excessive hair growth, rash, severe acne, skin lumps, easy bruising.

Head, Eyes, Ears, Nose & Throat: headaches, head injury, recent poor vision, earaches, sinus pain, nose bleeds, ringing in the ears, difficulty hearing, hoarse voice, lumps in the neck, swollen glands.

Lungs: persistent cough, coughing up blood or sputum, chronic shortness of breath, shortness of breath on exertion, wheezing.

Heart: chest pain, pressure or tightness, heart attack, heart murmur, waking at night short of breath, difficult breathing while lying down, irregular heartbeats, leg edema.

Gastrointestinal: nausea or vomiting, black or bloody stools, heartburn, difficult swallowing, persistent diarrhea, yellow skin, constipation, abdominal pain, abdominal surgery, removal of gallbladder, removal of appendix.

Bladder/Kidney: blood in urine, wake at night to urinate, pus in urine, kidney stone, urinate frequently, burning when you urinate, genital sores, urine urgency, excessive urine volume, difficulty urinating.

MEN ONLY: difficulty urinating, difficulty with erections, a sore on the penis, testicle pain, lump in testicles, vasectomy.

WOMEN ONLY: irregular periods, heavy periods, excessive hair growth, breast discharge, breast lumps, tubal ligation, hysterectomy, vaginal discharge, abnormal vaginal bleeding, hot flashes, taking birth control pills.

Do you or your partner use some form of contraception? ___ Yes, ___ No, ___ N/A.

Muscle-Skeletal: joint pains, muscle pains, back pain, joint redness or swelling, difficulty moving joints, muscle weakness, leg cramp after walking.

Endocrine: sweat easily, always feel hot or cold, radiation to face or neck, excessive sleepiness, increased or decreased appetite, tremor.

DIABETICS ONLY: sores on your feet, diabetic kidney disease, diabetic eye disease, frequent low blood sugars, “laser” eye surgery, abnormal feeling in your toes or feet.

Neurologic: fainting, seizures, tremor, dizziness, extremity weakness, insomnia, persistent headache.

Psychiatric: depression, hearing voices, anxiety, thoughts of suicide.

Is there anything else you would like Dr. Zhou to know about yourself?

NO_____

YES_____

OPTIONAL

Advanced Directives:

Do you have a “living will”? ___ No ___ Yes

Do you have a donor card? ___ No ___ Yes

Do you have a health care proxy? ___ No ___ Yes