History # _____ UPIN # _____

(Please leave blank)

Name: _____ _____ _____
First M.I. Last

Address:
Street (Apt #)

_____
City State Zip Code

Phone number: _(____)_____ ____(___)_____
Home Business

Birth Date: _____/_____/_____
Day-Month-Year

Gender: _____ _____
M F

Marital status: _____ (Maiden name _____)

Ethnic Background: ☐ Caucasian ☐ African-American ☐ Asian ☐ Hispanic ☐ Native American

Occupation: Current _____ Duration _____ _____
months years

Previous _____ _____ _____

_____ _____ _____

_____ _____ _____

Hobbies/Leisure activities: _____, _____, _____,

Toxic exposures with dates: (insecticides_____, solvents_____, chemicals_____,
fumes_____,asbestos _____,irradiation_____)

Family pets: _____, _____, _____

Foreign travel: ☐ Europe Dates _____
☐ Asia _____
☐ South America _____
☐ Africa _____

Tobacco use: Type _____ Amount _____ Duration_____

Alcohol use: Type _____ Amount _____ Duration _____

Family Medical History :

Father: ☐ living; age _____ ☐ deceased; age _____

Illnesses _____

Mother: ☐ living; age _____ ☐ deceased; age _____

Illnesses _____

Siblings: Brothers ☐ living ; ages _____, ☐ deceased; ages _____

Sisters ☐ living; ages _____, ☐ deceased; ages _____

Illnesses _____

Children: Male; ages _____ Female; ages _____

Illnesses _____

Diseases that run in the family: (circle all that apply)

Lung Disease	Skin Disease	Stroke	Cancer
Tuberculosis	Arthritis	Blood Clots	Gout
Heart Disease	Diabetes	Anemia	Kidney Stones
Kidney Disease	Hypertension	Leukemia	Birth Defects or
Liver Disease	Bleeding Disorders	Other Blood Disorders	Inherited Disorders

Personal Medical History:

Hospitalizations:	Dates:	_____ , _____ , _____
	Hospital	_____ , _____ , _____
	Reason	_____ , _____ , _____
Surgery:	Dates:	_____ , _____ , _____
	Hospital	_____ , _____ , _____
	Type	_____ , _____ , _____
Injuries:	Dates:	_____ , _____ , _____
	Type	_____ , _____ , _____

Medicine allergies: (Drug and type of reaction)_____, _____

Pregnancies: Full term _____ , _____ Miscarriages _____, _____

Personal Medical History (Continued):

Current medications:(including vitamins and nonprescription drugs)

_____, _____, _____, _____,
_____, _____, _____, _____

Immunizations (with dates):

Tetanus_____, Pneumovax_____, Influenza_____, Hepatitis A_____, Hepatitis B_____

Blood donations given, Dates: _____, _____, _____

Blood transfusions received, Dates:_____, _____, _____

Blood studies performed: ☐ Bone marrow aspiration, Dates _____

☐Bone marrow biopsy, Dates _____ ☐

Symptom Review (Check and complete all that apply)

Constitutional: Have you recently experienced ?

☐ Fever
☐ Night sweats
☐ Weight loss, Amount ____
☐ Poor appetite,
☐ Weight gain, Amount _____
☐ Lack of energy
☐ Weakness
☐ Difficulty sleeping.

Head

☐ Headaches; Type _____ Duration _____Treatment _____
Earache ☐ Right ear ☐ Left ear
Loss of hearing, ☐ Right ear ☐ Left ear
Ringing in the ear ☐ Right ear ☐ Left ear
☐ Dizziness or vertigo
Loss of vision ☐ Right eye ☐ Left eye
☐ Double vision
☐ Spots or flashing lights ☐ Right eye ☐ Left eye
☐ Nose bleeds
☐ Sinusitis
☐ Gum bleeding
☐ Sore or burning tongue
☐ Mouth ulcers or sores

Neck

☐ Sore throat
☐ Hoarseness
☐ Swelling
☐ History of thyroid disease or goiter, Date _____, Treatment
☐ Heat or ☐ Cold intolerance, Duration _____

Chest

☐ Pain
☐ Cough
☐ Asthma
☐ Sputum production
☐ Snoring or sleep apnea
☐ Bloody sputum
Shortness of breath; ☐ At rest ☐ With exertion ☐ Lying down
☐ Last chest x-ray; Date_____
TB skin test; ☐ Positive; ☐ Negative; Dates _____, _____

Breasts: ☐ Pain ☐ Lumps, cysts ☐ Discharge

Heart: ☐ Rheumatic Fever ☐ Heart murmur, Duration _____ ☐ Hypertension, Duration_____
☐ Irregular heart beat, Duration _____ ☐ History of heart attack, Date _____
☐ Chest pain with exertion, Duration_____ ☐ Ankle swelling, Duration_____
☐ Pain in legs when walking, Duration _____

Abdomen

- ☐ Inability to eat a full meal
- ☐ Change in abdominal size
- ☐ Difficulty swallowing
- ☐ Heart burn or Acid-indigestion
- ☐ Peptic ulcer
- ☐ Food intolerance, type _____
- ☐ Antacid use
- ☐ Hiatus hernia
- ☐ Specific food or ice craving
- ☐ Abdominal pain
  Location _____
  Duration _____
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Liver disease
- ☐ Vomiting
- ☐ Vomiting blood
- ☐ Blood in the stool
- ☐ Black or tarry stools
- ☐ Change in bowel habits, Duration _____
- ☐ Constipation
- ☐ Diarrhea
- ☐ Laxative use, type _____

Genitourinary Tract

- ☐ Pain with urination
- ☐ Bleeding
- ☐ Urinary urgency
- ☐ Increased frequency
- ☐ Kidney stones
- ☐ Kidney infection, Dates _____
- ☐ Bladder infection, Dates _____
- ☐ Change in urine color
- ☐ Getting up at night to urinate
  Duration _____
- ☐ Bleeding between menstrual periods
  Duration _____
- ☐ Excessive menstrual bleeding
  Duration _____
- ☐ Vaginal infection
- ☐ Vaginal discharge

Bones and Joints

- ☐ Joint pain
- ☐ Joint swelling
- ☐ Joint stiffness
- ☐ Gout
- ☐ Pain in the arms, legs, hands or feet
- ☐ Burning pains in the hands or feet
- ☐ Numbness or tingling (pins and needles in hands or feet)

Muscles

- ☐ Muscle pain
- ☐ Muscle stiffness
- ☐ Muscle cramps

Nervous System

- ☐ Fainting episodes
- ☐ Seizures
- ☐ Stroke
- ☐ Temporary loss of vision
- ☐ Memory loss
- ☐ Difficulty sleeping
- ☐ Depression

Blood:

- ☐ Anemia, Dates: _____, _____,Treatment _____ Result _____
- ☐ Abnormal blood counts, Type _____, Dates: _____
- ☐ Bleeding; Dates _____ Treatment _____
- ☐ Phlebitis or blood clots; Site _____ Dates _____, _____
- ☐ Swollen lymph nodes, location _____

Skin:

- ☐ Rash
- ☐ Itching after a shower, bath or exercise
- ☐ Hair loss
- ☐ Hair gain
- ☐ Excema
- ☐ Psoriasis
- ☐ Change in skin color
- ☐ Change in skin texture

Present Illness:

Provide a description of your illness with dates of onset of symptoms, tests performed and treatments given. Please also indicate your concerns. Use additional paper as needed.

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