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	Arthrits-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	Skin 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 Cholesteral_____

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