REVISED VERSION

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(800) 247-2343

Patient Data Base System

In order to provide you with more effective medical care, your doctor needs certain basic information about your medical history. The few minutes you spend completing this booklet will be an important contribution to your overall health care.

Please read all instructions carefully before answering any questions. Take whatever time you need to finish each section. Don't worry if you can't remember, or aren't sure of the answer to any part or question. You'll have a chance to go over it afterwards with the doctor.

Thank you.

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R905 Reviewed06

IDENTIFICATION DATA Please **print** the following information.

Today's date_____/_____/_____ File no.______________________

Name ____

____Male ____Female ____Race Date of birth _____/_____/_____

Address ____

___Married ___Separated ___Divorced ___Widowed ___Single

____ ________________ Zip Code

Education ____years Elementary ____years High School ____years College, Business, etc.

Telephone ____ Home number Work number

Social Security or Medicare No.______________________________

Occupation ____

FAMILY HISTORY: For each member of your family, follow the grey or white line across the page and check the boxes for:
1. Their present state of health 2. Any illnesses they have had

(Note: except for *spouse*, Family refers to *blood* or *natural* relatives.)

PRINT NAMES BELOW	Good health	Poor health	Deceased	Write in age and cause of death. Include fatal accidents and suicides.	Allergies or asthma	High cholesterol	Blood clotting problems	Diabetes	Cancer or tumor	Stroke	Glaucoma	Genetic disease	Alcoholism	Kidney or bladder trouble	Stomach/duodenal ulcer	Mental illness	Rheumatism or arthritis	High blood pressure	Heart trouble	Dementia	Gout
Father:																					
Mother:																					
Brothers/Sisters:																					
Spouse:																					
Child:																					
Child:																					
Child:																					
Child:																					
Father's relatives (in each box, write how many affected with) →																					
Mother's relatives (in each box, write how many affected with) →																					
→ Begin YOUR HEALTH HISTORY here. Have you had: →																					

Additional Illnesses or Problems: Mark an X in the box next to any of the following that you have now or have ever had.

☐ eye infections
☐ thyroid disease
☐ eczema
☐ hives or rashes
☐ bronchitis
☐ emphysema
☐ hepatitis
☐ pneumonia
☐ pancreatitis
☐ liver disease
☐ diverticulosis
☐ hernia
☐ hemorrhoids
☐ blood transfusion
☐ neuralgia or neuritis
☐ tension/anxiety
☐ depression
☐ childhood hyperactivity
☐ chicken pox
☐ German measles
☐ drug abuse
☐ scarlet fever
☐ measles
☐ mumps
☐ polio
☐ rheumatic fever
☐ malaria
☐ osteoporosis
☐ mononucleosis
☐ sexually transmitted disease
☐ yellow jaundice
☐ tuberculosis
☐ high cholesterol
☐ ________________

Major Hospitalizations: If you have ever been hospitalized for any major medical illness or operation, write in your most recent hospitalizations below. Check this box ☐ if you have had more than four such hospitalizations. (Do not include normal pregnancies.)

	Year	Operation or Illness	Name of Hospital	City and State
1st Hospitalization				
2nd Hospitalization				
3rd Hospitalization				
4th Hospitalization				

Tests and Immunizations: Mark an X next to those that you have had. Enter the year when you last were given the tests or "shots".

Year
☐ _______chest x-ray
☐ _______kidney x-ray
☐ _______gastrointestinal series
☐ _______colon x-ray
☐ _______gallbladder x-ray
☐ _______electrocardiogram
☐ _______TB test
☐ _______sigmoidoscopy
☐ _______colonoscopy
☐ _______PSA (prostate cancer screen)

Year
☐ _______Pap smear
☐ _______mammogram
☐ _______tetanus "shots"
☐ _______polio series
☐ _______flu injections
☐ _______mumps "shots"
☐ _______measles "shots"
☐ _______hepatitis series
☐ _______pneumonia shot

Current Medications (include vitamins, supplements and over the counter drugs):

Medications	Dose	How Often

Allergies	Reaction

Your Signature____

CONTINUE TO NEXT PAGE

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- Answer each question by writing an X on either the No or Yes line.
- Where a question asks for specific information, write the answer on the line next to the question number on the last page.
- If you don't understand a question, or would especially like to discuss it with the doctor, circle its number on the last page (Example: ____Yes (17.)).

1. Do you have any skin problems? .... No____
2. Does your skin itch or burn? .... No____
3. Do you have trouble stopping even a small cut from bleeding? .... No____
4. Do you bruise easily? .... No____

5. Do you ever faint or feel faint? .... No____
6. Is any part of your body always numb? .... No____
7. Have you ever had seizures or convulsions? .... No____
8. Has your handwriting changed lately? .... No____
9. Do you have a tendency to shake or tremble? .... No____

10. Are you very nervous around strangers? .... No____
11. Do you find it hard to make decisions? .... No____
12. Do you find it hard to concentrate or remember? .... No____
13. Do you usually feel lonely or depressed? .... No____
14. Do you often cry? .... No____
15. Would you say you have a hopeless outlook? .... No____
16. Do you have difficulty relaxing? .... No____
17. Do you have a tendency to worry a lot? .... No____
18. Are you troubled by frightening dreams or thoughts? .... No____
19. Do you have a tendency to be shy or sensitive? .... No____
20. Do you have a strong dislike for criticism? .... No____
21. Do you lose your temper often? .... No____
22. Do little things often annoy you? .... No____
23. Are you disturbed by any work or family problems? .... No____
24. Are you having any sexual difficulties? .... No____
25. Have you ever considered committing suicide? .... No____
26. Have you ever desired or sought psychiatric help? .... No____
27. Have you ever been the victim of abuse (physical, sexual, emotional)? .... No____

28. Have you gained or lost more than 10 pounds in the last 6 months? .... No____
29. Do you have a tendency to be too hot or too cold? .... No____
30. Have you lost your interest in eating lately? .... No____
31. Do you always seem to be hungry? .... No____
32. Are you more thirsty than usual lately? .... No____
33. Are there any swellings in your armpits or groin? .... No____
34. Do you seem to feel exhausted or fatigued most of the time? .... No____
35. Do you have difficulty either falling asleep or staying asleep? .... No____
36. Do you exercise more than three times a week? .... **Yes**____
37. How much do you smoke per day? ....

____

38. Do you take two or more alcoholic drinks a day? .... No____
39. Do you drink more than six cups/glasses of coffee, tea or cola a day? .... No____
40. Are you a regular user of sleeping pills, marijuana, tranquilizers, pain killers, etc? No____
41. Have you ever used heroin, cocaine, LSD, PCP, meth, etc? .... No____
42. Do you drive a motor vehicle more than 25,000 miles a year? .... No____
43. How often do you use seat belts when riding in cars? ....

____

44. List any country outside the United States you have visited in the past six months ......

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TURN TO THE NEXT PAGE →

45. Are you troubled by heartburn? . . . . No____
46. Do you feel bloated after eating? . . . . No____
47. Are you troubled by belching? . . . . No____
48. Do you suffer discomfort in the pit of your stomach? . . . . No____
49. Do you easily become nauseated (feel like vomiting)? . . . . No____
50. Have you ever vomited blood? . . . . No____
51. Is it difficult or painful for you to swallow? . . . . No____
52. Are you constipated more than twice a month? . . . . No____
53. Are your bowel movements ever loose for more than one day? . . . . No____
54. Are your bowel movements ever black or bloody? . . . . No____
55. Do you suffer pains when you move your bowels? . . . . No____
56. Have you had any bleeding from your rectum? . . . . No____

57. Do you frequently get up at night to urinate? . . . . No____
58. Do you urinate more than five or six times a day? . . . . No____
59. Do you wet your pants or wet your bed? . . . . No____
60. Have you ever had burning or pains when you urinate? . . . . No____
61. Has your urine ever been brown, black or bloody? . . . . No____
62. Do you have any difficulty starting your urine flow? . . . . No____
63. Do you have a constant feeling that you have to urinate? . . . . No____

For Men Only

64. Are you homosexual or bisexual? . . . . No____
65. Have you had more than 5 sexual partners? . . . . No____
66. Is your urine stream very weak and slow? . . . . No____
67. Has a doctor ever told you that you have prostate trouble? . . . . No____
68. Have you had any burning or discharge from your penis? . . . . No____
69. Are there any swellings or lumps on your testicles? . . . . No____
70. Do your testicles get painful? . . . . No____
71. Write in the month and year of your last PSA (Prostate Cancer Screening)

For Women Only

72. What was the date of your last menstrual period? . . . .
73. Are you past your menopause, or have you had a hysterectomy? . . No____
74. If yes: Have you noticed any vaginal bleeding since? . . . . No____
(Please now skip to question 78)
75. Was your last menstrual period normal? . . . . **Yes**____
76. Do you have heavy bleeding with your periods? . . . . No____
77. Have you had bleeding between your periods? . . . . No____
78. Do you ever have bleeding after intercourse? . . . . No____
79. Have you had any recent vaginal itching or discharge? . . . . No____
80. Do you examine your breasts at least once a month? . . . . **Yes**____
81. Have you ever noticed any lumps or pain in your breasts? . . . . No____
82. Have you had complications with any type of birth control? . . . . . . No____
83. Write in the month and year of your last Pap test . . . .

Print the following information in the spaces at the right:

84. Numbers of pregnancies . . . .
85. Number of children born alive . . . .
86. Number of premature births . . . .
87. Number of miscarriages . . . .
88. Number of stillbirths . . . .
89. Have you ever had an abortion . . . . No____

Questions 90-138 For Both Men and Women

90. Are you troubled with stiff and painful muscles or joints? . . . . No____
91. Are your joints ever swollen? . . . . No____
92. Are you troubled by pains in the back or shoulder? . . . . No____
93. Are your feet often painful? . . . . No____
94. Are you handicapped in any way? . . . . No____

TURN TO THE BACK OF THIS PAGE →

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Please print your name and today's date in the spaces at the right:

95. Do you have headaches more than once a week? No____
96. Does twisting your neck quickly cause pain? No____
97. Have you ever had lumps or swelling in your neck? No____

98. Do you wear glasses? No____
99. Does your eyesight ever blur? No____
100. Is your eyesight getting worse? No____
101. Do you ever see double? No____
102. Do you ever see colored halos around lights? No____
103. Do you ever have pains or itching in or around your eyes? No____
104. Do your eyes blink or water most of the time? No____
105. Have you had any trouble with your eyes in the last two years? No____

106. Do you have difficulty hearing? No____
107. Have you had any earaches lately? No____
108. Have you been troubled by ringing ears lately? No____
109. Do you have a repeated buzzing or other noises in your ears? No____
110. Do you get motion sickness riding in a car or plane? No____

111. Do you have any problems with your teeth? No____
112. Do you have any sore swellings on your gums or jaws? No____
113. Is your tongue sore or sensitive? No____
114. Have your taste senses changed lately? No____

115. Is your nose stuffed up when you don't have a cold? No____
116. Does your nose run when you don't have a cold? No____
117. Do you ever have sneezing spells? No____
118. Do you ever have head colds two or more months in a row? No____
119. Does your nose ever bleed for no reason at all? No____
120. Is your throat ever sore when you don't have a cold? No____
121. Has a doctor told you that your tonsils have been enlarged? No____
122. Has your voice ever been hoarse when you didn't have a cold? No____

123. Do you wheeze or have to gasp to breathe? No____
124. Are you bothered by coughing spells? No____
125. Do you cough up a lot of phlegm (thick spit)? No____
126. Have you ever coughed up blood? No____
127. Do you get chest colds more than once a month? No____
128. Are you sweating more than usual or having night sweats? No____

129. Have you ever been told that you had high blood pressure? No____
130. Have you been bothered by a thumping or racing heart? No____
131. Do you ever get pains or tightness in your chest? No____
132. Do you have trouble with dizziness or lightheadedness? No____
133. Does every little effort leave you short of breath? No____
134. Do you wake up at night short of breath? No____
135. Are you using more pillows to help you breathe at night? No____
136. Do you have trouble with swollen feet or ankles? No____
137. Are you getting cramps in your legs at night or upon walking? No____
138. Have you ever been told that you have a heart murmur? No____

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Now, in the blank lines at the right please describe any special problems or symptoms that you wish to discuss with the doctor.

END

Name______________________________ Date____/____/____ Patient no.______________

Doctor's notes ______________________________

____

____

HEAD AND NECK

95. Yes ____ frequent headaches
96. Yes ____ neck pains
97. Yes ____ neck lumps or swelling

EYES

98. Yes ____ wears glasses
99. Yes ____ blurry vision
100. Yes ____ eyesight worsening
101. Yes ____ sees double
102. Yes ____ sees halo
103. Yes ____ eye pains or itching
104. Yes ____ watering eyes
105. Yes ____ eye trouble

EARS

106. Yes ____ hearing difficulties
107. Yes ____ earaches
108. Yes ____ ringing ears
109. Yes ____ buzzing in ears
110. Yes ____ motion sickness

MOUTH

111. Yes ____ dental problems
112. Yes ____ swellings on gums or jaws
113. Yes ____ sore tongue
114. Yes ____ taste changes

NOSE and THROAT

115. Yes ____ congested nose
116. Yes ____ running nose
117. Yes ____ sneezing spells
118. Yes ____ headcolds
119. Yes ____ nose bleeds
120. Yes ____ sore throat
121. Yes ____ enlarged tonsils
122. Yes ____ hoarse voice

RESPIRATORY

123. Yes ____ wheezes or gasps
124. Yes ____ coughing spells
125. Yes ____ coughs up phlegm
126. Yes ____ coughed up blood
127. Yes ____ chest colds
128. Yes ____ more sweating, night sweats

CARDIOVASCULAR

129. Yes ____ high blood pressure
130. Yes ____ racing heart
131. Yes ____ chest pains
132. Yes ____ dizzy spells
133. Yes ____ shortness of breath
134. Yes ____ shortness of breath at night
135. Yes ____ more pillows to breathe
136. Yes ____ swollen feet or ankles
137. Yes ____ leg cramps
138. Yes ____ heart murmur

DIGESTIVE

heartburn ____ Yes 45.
bloated stomach ____ Yes 46.
belching ____ Yes 47.
stomach pains ____ Yes 48.
nausea ____ Yes 49.
vomited blood ____ Yes 50.
difficulty swallowing ____ Yes 51.
constipation ____ Yes 52.
loose bowels ____ Yes 53.
black stools ____ Yes 54.
pain in rectum ____ Yes 55.
rectal bleeding ____ Yes 56.

URINARY

night frequency ____ Yes 57.
day frequency ____ Yes 58.
wets pants or bed ____ Yes 59.
burning on urination ____ Yes 60.
brown, black or bloody urine ____ Yes 61.
difficulty starting urine ____ Yes 62.
urgency ____ Yes 63.

MALE GENITAL

homosexual/bisexual ____ Yes 64.
more than 5 sexual partners ____ Yes 65.
weak urine stream ____ Yes 66.
prostate trouble ____ Yes 67.
burning or discharge ____ Yes 68.
lumps on testicles ____ Yes 69.
painful testicles ____ Yes 70.
last PSA ____/____ 71.
Mo. Yr.

FEMALE GENITAL

last menstrual period __/__/__ 72.
post-menopausal or hysterectomy ____ Yes 73.
noticed vaginal bleeding ____ Yes 74.

normal LMP ____ **No** 75.
heavy bleeding during periods ____ Yes 76.
bleeding between periods ____ Yes 77.
bleeding after intercouse ____ Yes 78.
recent vaginal itching/discharge ____ Yes 79.
monthly breast exam ____ **No** 80.
lump or pain in breasts ____ Yes 81.
complications with birth control ____ Yes 82.
last Pap test ____/____ 83.
Mo. Yr.

OBSTETRIC HISTORY

gravida ________ 84.
para ________ 85.
pre-term ________ 86.
miscarriages ________ 87.
still births ________ 88.
has had an abortion ____ Yes 89.

MUSCULOSKELETAL

aching muscles or joints ____ Yes 90.
swollen joints ____ Yes 91.
back or shoulder pains ____ Yes 92.
painful feet ____ Yes 93.
handicapped ____ Yes 94.

SKIN

skin problems ____ Yes 1.
itching or burning skin ____ Yes 2.
bleeds easily ____ Yes 3.
bruises easily ____ Yes 4.

NEUROLOGICAL

faintness ____ Yes 5.
numbness ____ Yes 6.
convulsions ____ Yes 7.
change in handwriting ____ Yes 8.
trembles ____ Yes 9.

MOOD

nervous with strangers ____ Yes 10.
difficulty in making decisions ____ Yes 11.
lack of concentration or memory ____ Yes 12.
lonely or depressed ____ Yes 13.
cries often ____ Yes 14.
hopeless outlook ____ Yes 15.
difficulty relaxing ____ Yes 16.
worries a lot ____ Yes 17.
frightening dreams or thoughts ____ Yes 18.
shy or sensitive ____ Yes 19.
dislikes criticism ____ Yes 20.
loses temper ____ Yes 21.
annoyed by little things ____ Yes 22.
work or family problems ____ Yes 23.
sexual difficulties ____ Yes 24.
considered suicide ____ Yes 25.
desired psychiatric help ____ Yes 26.
victim of abuse ____ Yes 27.

GENERAL

gained/lost more than 10 pounds ____ Yes 28.
tends to be too hot or cold ____ Yes 29.
loss of interest in eating ____ Yes 30.
always hungry ____ Yes 31.
more thirsty lately ____ Yes 32.
armpits or groin swelling ____ Yes 33.
exhausted or fatigued ____ Yes 34.
sleeping difficulties ____ Yes 35.
exercises more than 3X per week ____ **No** 36.
per day smokes ____cigarettes 37.
per day smokes ____cigars/pipes
doesn't smoke
2+ alcoholic drinks per day ____ Yes 38.
6+cups/glass, cof., tea, cola daily ____ Yes 39.
sleeping pills, marijuana, tranq. ____ Yes 40.
has used hard drugs ____ Yes 41.
drives over 25,000 miles per year ____ Yes 42.
uses seat belts ____never 43.
____sometimes
always
visited in last 6 months ________ 44.
____

Your Signature:______________________________

Special problems or symptoms:______________________________

____

____

____

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Data Base System
PHYSICAL EXAMINATION

Use the following codes to indicate findings for those categories reviewed during this examination.
✓ WNL = All category items are within normal limits   POS = An item with positive findings
X = Mark an X across names of categories not examined

GENERAL ☐ WNL
a. Posture ____
b. Gait ____
c. Speech ____
d. Appearance ____
e. Emotion ____

HEAD ☐ WNL
a. Hair ____
b. Masses ____
c. Shape ____
d. Bruits ____
e. Tenderness ____
f. Sinus ____

EYES ☐ WNL
a. Lids R__ L__
b. Sclera R__ L__
c. Conjunctiva R__ L__
d. Muscles R__ L__
e. Cornea R__ L__
f. Pupils R__ L__
g. Fundi R__ L__
h. Light R__ L__
j. Accommodation R__ L__

EARS ☐ WNL
a. Pinna R____ L____
b. Canal R____ L____
c. Drum R____ L____
d. Weber ____
e. Rinne ____

NOSE ☐ WNL
a. Septum ____
b. Mucosa R __L __
c. Obstruction ____

MOUTH/THROAT ☐ WNL
a. Lips ____
b. Breath ____
c. Tongue ____
d. Pharynx ____
e. Tonsils ____
f. Teeth ____
g. Dentures ____
h. Caries ____
i. Floor ____
j. Mucosa ____

NECK ☐ WNL
a. Thyroid ____
b. Trachea ____
c. Veins ____
d. Spine ____
e. Nodes R__L__
f. Bruit R__L__
g. Carotid R__L__
h. Motion ____

RESPIRATORY ☐ WNL
a. Chest ____
b. Symmetry ____
c. Rubs ____
d. Labored ____
e. Sounds ____
f. Fremitus ____
g. Cough ____

HEART ☐ WNL
a. PMI ____
b. Rate ____
c. Rhythm ____
d. Thrill ____
e. Tones ____
f. Rub ____
g. Murmurs ____
h. Gallops ____

BREASTS ☐ WNL
a. Nodes R__ L__
b. Discharge R__ L__
c. Nipple R__ L__
d. Areolar R__ L__
e. Symmetry R__ L__
f. Consistency R__ L__
g. Scars R__ L__

ABDOMEN ☐ WNL
a. Contour ____
b. Tenderness ____
c. Organs ____
d. Masses ____
e. Hernia R __L __
f. Bruit R __L __
g. Sounds R __L __
h. Femoral Pulse R __L __
i. Ing. Nodes R __L __

BACK ☐ WNL
a. Curvation ____
b. Mobility ____
c. Tenderness
CVA Renal ____
Bone ____

FEMALE GENITALS ☐ WNL
a. Labia ____
b. Bartholin's gland ____
c. Urethra ____
d. Vagina ____
e. Cervix ____
f. Uterus ____
g. Adnexa R___ L____
h. Pap smear done ____
i. Discharge ____
j. STD culture done____

MALE GENITALS ☐ WNL
a. Penis ____
b. Scrotum ____
c. Testicles ____
d. Discharge ____
e. Scars ____
f. Meatus ____
g. Epididymis ____
h. Varicocele ____

RECTAL ☐ WNL
a. Pilonidal ____
b. Anus ____
c. Sphincter ____
d. Fissure ____
e. Prostate ____
f. Masses ____
g. Hemorrhoids ____
h. Mucosa ____
i. Other ____

SKIN ☐ WNL
a. Scars ____
b. Birthmarks ____
c. Other marks ____
d. Texture ____
e. Sweat ____
f. Color ____
g. Ulcers ____

NEUROLOGIC ☐ WNL

	Strength*	Reflex**
a. Biceps	R____ L____	R____ L____
b. Triceps	R____ L____	R____ L____
c. Knee	R____ L____	R____ L____
d. Ankle	R____ L____	R____ L____

e. Romberg ____
f. Babinski ____
g. Cranial N ____
h. Sensory ____
i. Coordination ____
j. Tremor ____
k. Vibratory ____

EXTREMITIES ☐ WNL
a. Shoulder R____ L____
b. Arm R____ L____
c. Elbow R____ L____
d. Radial Pulse R____ L____
e. Wrist R____ L____
f. Hand R____ L____
g. Fingers R____ L____
h. Nails R____ L____
i. Hip R____ L____
j. Leg R____ L____
k. Knee R____ L____
l. Ankle R____ L____
m. Foot R____ L____
n. Pedal Pulse R____ L____
o. Toes R____ L____
p. Nails R____ L____

* When testing strength use grades: Weak (W); Normal (N); Strong (S)
** When testing reflexes use: Absent (A); Present (P); Brisk (B)

Signature ________________________________

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Patient name________________________ Date____/____/____ Number____________

Height ______ in. Weight ______ lb. Pulse__________ Temp.________

Build (circle) sm. med. lg. obese Resp.___________

Blood Pressure

R: _______/______

L: _______/______

If above 140/90 do after 5 min.

R: _______/______

L: _______/______

Optometry

	Vision	Jaeger
Uncorrected:	R 20/________	R ________
	L 20/________	L ________
Corrected:	R 20/________	R ________
	L 20/________	L ________

Tonometry: R ____ L ____

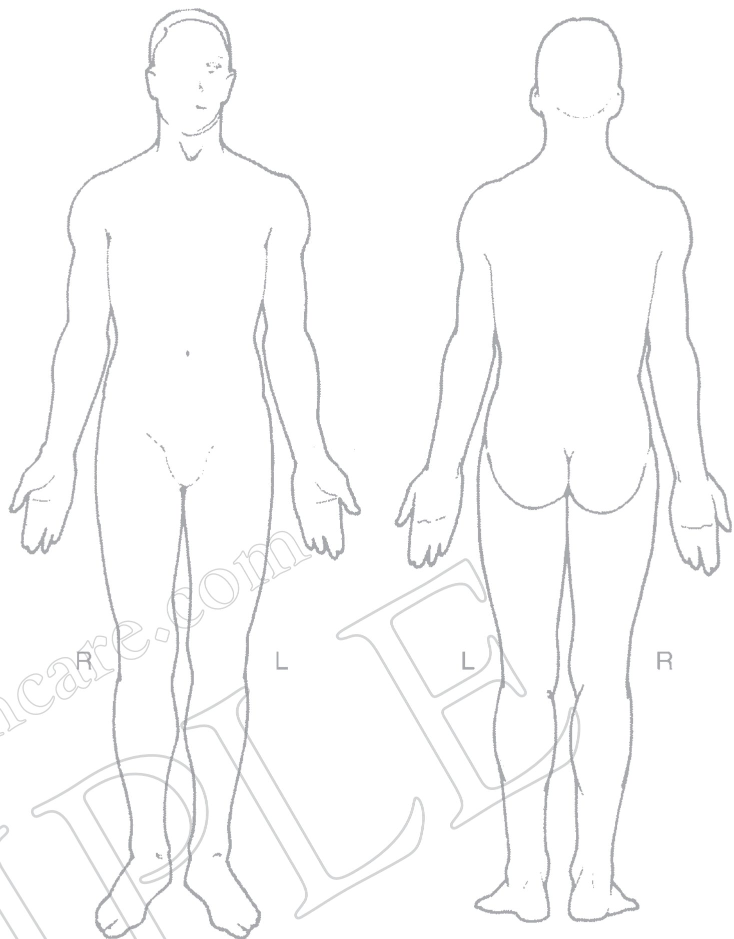
Color deficiency: ☐ Yes ☐ No

Ishihara plates missing ______

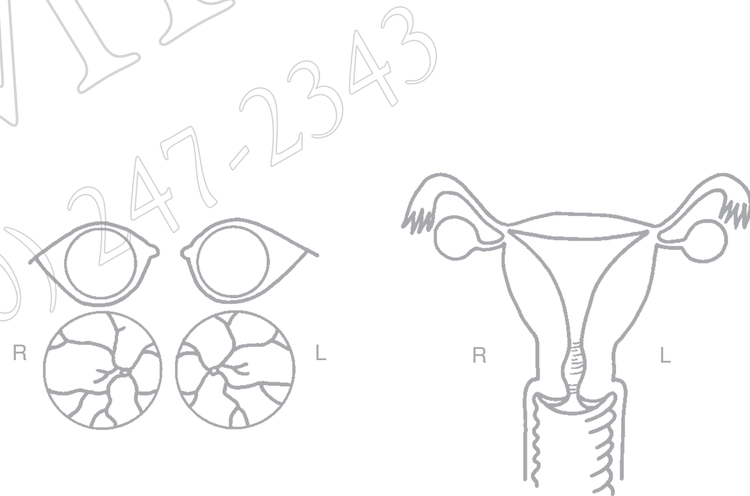
Audiometric Testing

	250	500	1000	2000	4000	8000
R	_____	_____	_____	_____	_____	_____
L	_____	_____	_____	_____	_____	_____

Gross Hearing ☐ **WNL** or: ______________________



Diagnostic Tests	Results
Urine (circle)	Nl. or Abn.
Hgb or Hemat	gm% per %
WBC/Diff.	# per Nl. or Abn.
Calcium/Phosp.	mg% per mg%
FBS	mg%
Uric Acid	mg%
BUN or Creat	mg% per mg%
Cholesterol	mg%
Total Protein/Alb.	gm% per gm%
Bilirubin	
Alk. Phosp.	mU/ml
LDH	mU/ml
SGOT	mU/ml
Triglycerides	mg%
Chest X-ray	check if done ☐
Back X-ray	check if done ☐
SGPT	mU/ml
GGTP	mU/ml
LAP	mU/ml
HAA	titer
PPD (circle)	Pos. or Neg.
Alpha 1 Antitrypsin	1 per titer
Na/K	mg% per mg%
Platelet Count	#



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Doctor's notes____

____

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____

____

____

____