

Name _____ Today's Date _____
 Age _____ Birthdate _____ Date of last physical exam _____
 Are you presently under a physician's care for any condition? Yes No
 If yes, please state condition _____ Name of physician _____
 What is the reason for today's visit? _____

SYMPTOMS Check (✓) symptoms you currently have or have had in the past year

<p>CONSTITUTIONAL</p> <input type="checkbox"/> Chills <input type="checkbox"/> Fainting <input type="checkbox"/> Fever <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Loss of weight <input type="checkbox"/> Nervousness <input type="checkbox"/> Sweats <p>EARS, NOSE, THROAT, MOUTH</p> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Difficulty swallowing <input type="checkbox"/> Earache <input type="checkbox"/> Ear discharge <input type="checkbox"/> Hoarseness <input type="checkbox"/> Loss of hearing <input type="checkbox"/> Nosebleeds <input type="checkbox"/> Ringing in ears <input type="checkbox"/> Sinus problems <p>EYES</p> <input type="checkbox"/> Blurred vision <input type="checkbox"/> Crossed eyes <input type="checkbox"/> Double vision <input type="checkbox"/> Redness <input type="checkbox"/> Visual flashes/halos <input type="checkbox"/> Watering <p>ALLERGIC/IMMUNOLOGIC</p> <input type="checkbox"/> Hay fever <p>HEMATOLOGIC</p> <input type="checkbox"/> Bleeding disorders	<p>SKIN</p> <input type="checkbox"/> Bruise easily <input type="checkbox"/> Change in moles <input type="checkbox"/> Hives <input type="checkbox"/> Itching <input type="checkbox"/> Jaundice <input type="checkbox"/> Rash <input type="checkbox"/> Scars <input type="checkbox"/> Sore won't heal <p>CARDIOVASCULAR</p> <input type="checkbox"/> Chest pain <input type="checkbox"/> Irregular heart beat <input type="checkbox"/> High blood pressure <input type="checkbox"/> Low blood pressure <input type="checkbox"/> Poor circulation <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> Swelling of ankles <input type="checkbox"/> Varicose veins <p>NEUROLOGICAL</p> <input type="checkbox"/> Dizziness <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Headache <input type="checkbox"/> Loss of consciousness <input type="checkbox"/> Numbness location _____ <input type="checkbox"/> Shaking <p>GENITO-URINARY</p> <input type="checkbox"/> Blood in urine <input type="checkbox"/> Frequent urination <input type="checkbox"/> Lack of bladder control <input type="checkbox"/> Painful urination <input type="checkbox"/> Urgency	<p>GU: MALES</p> <input type="checkbox"/> Discharge <input type="checkbox"/> Testicular mass <input type="checkbox"/> Testicular tenderness <p>GU: FEMALES</p> <input type="checkbox"/> Bleeding between periods <input type="checkbox"/> Breast lump <input type="checkbox"/> Extreme menstrual pain <input type="checkbox"/> Hot flashes <input type="checkbox"/> Nipple discharge <input type="checkbox"/> Painful intercourse <input type="checkbox"/> Vaginal discharge <p>Date of last menstrual period _____</p> <p>Pads/tampons per day _____</p> <p>Douche: <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Date of last Pap smear _____</p> <p><input type="checkbox"/> normal <input type="checkbox"/> abnormal</p> <p>Are you pregnant? <input type="checkbox"/> yes <input type="checkbox"/> no</p> <p>Number of children _____</p> <p>Date of last mammogram _____</p> <p>ENDOCRINE</p> <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Goiter <input type="checkbox"/> Growth changes <p>RESPIRATORY</p> <input type="checkbox"/> Asthma <input type="checkbox"/> Coughing up blood <input type="checkbox"/> Difficulty breathing <input type="checkbox"/> Persistent cough <input type="checkbox"/> Wheezing	<p>MUSCLE/JOINT/BONE</p> <p>Pain, weakness, numbness in:</p> <input type="checkbox"/> Arms <input type="checkbox"/> Hips <input type="checkbox"/> Back <input type="checkbox"/> Legs <input type="checkbox"/> Feet <input type="checkbox"/> Neck <input type="checkbox"/> Hands <input type="checkbox"/> Shoulders <input type="checkbox"/> Fracture _____ <p>GASTROINTESTINAL</p> <input type="checkbox"/> Appetite poor <input type="checkbox"/> Bloating <input type="checkbox"/> Bowel habit changes <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Excessive hunger <input type="checkbox"/> Excessive thirst <input type="checkbox"/> Gas <input type="checkbox"/> Heartburn <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Indigestion <input type="checkbox"/> Nausea <input type="checkbox"/> Rectal bleeding <input type="checkbox"/> Stomach pain <input type="checkbox"/> Vomiting <input type="checkbox"/> Vomiting blood <p>OTHER (Please list):</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Date of last: Colonoscopy: _____ Chest X-ray: _____ EKG: _____</p>
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CONDITIONS Check (✓) conditions you currently have or have had in the past year

<input type="checkbox"/> Abnormal pap	<input type="checkbox"/> Breast lump	<input type="checkbox"/> Goiter	<input type="checkbox"/> HIV positive	<input type="checkbox"/> Prostatitis	<input type="checkbox"/> Urethral dis/inf
<input type="checkbox"/> AIDS	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Gonorrhea	<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Psychiatric care	<input type="checkbox"/> Vaginal infections
<input type="checkbox"/> Alcoholism	<input type="checkbox"/> Bulimia	<input type="checkbox"/> Gout	<input type="checkbox"/> Kidney disease	<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Other (list): _____
<input type="checkbox"/> Anemia	<input type="checkbox"/> Cancer	<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Liver disease	<input type="checkbox"/> Sexual trans. dis	_____
<input type="checkbox"/> Angina	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Headaches	<input type="checkbox"/> Migraines	<input type="checkbox"/> Stroke	_____
<input type="checkbox"/> Anorexia	<input type="checkbox"/> Chem. dependency	<input type="checkbox"/> Hernia	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Suicide attempt	_____
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Herpes	<input type="checkbox"/> Multiple sclerosis	<input type="checkbox"/> Thyroid problems	_____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Tonsillitis	_____
<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Epilepsy	<input type="checkbox"/> High blood pressure	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Tuberculosis	_____
<input type="checkbox"/> Blood clots	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> High cholesterol	<input type="checkbox"/> Polio	<input type="checkbox"/> Ulcers	_____

MEDICATIONS List medications you are currently taking (include dosage)

1.	3.	5.	7.	9.
2.	4.	6.	8.	10.

Pharmacy Name: _____ Phone number: _____

ALLERGIES or ADVERSE REACTIONS TO MEDICATIONS OR SUBSTANCES

1.	2.	3.
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Plaza 2
1301 South Cliff Avenue, Suite 400
Sioux Falls SD 57105

FAMILY HISTORY (Complete health information about your family)

Relation	Age	State of health	Age at death	Cause of death	Check (✓) if your blood relatives had any of the following:	
					Disease	Relationship
Father					Arthritis, Gout	
Mother					Asthma, Hay fever	
Brothers					Cancer, type _____	
					Chemical Dependency	
Sisters					Diabetes	
					High blood pressure; stroke	
Grand-parents					Heart disease	
					Kidney disease	

PREGNANCY HISTORY (Include miscarriage, abortion, etc.)

Year of Birth	Sex of Birth	Complication, if any

HEALTH HABITS (Check (✓) which substances you use and describe how much you use and/or how often habit is engaged in)

Have you ever had a blood transfusion? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please give approximate date(s):	Caffeine		
	Drugs		
	Tobacco		
	Seatbelts		
	Exercise		
	Self breast exam		
	Self-testicular exam		

OCCUPATIONAL CHOICES

Check (✓) if your work exposes you to the following	Do you feel safe at home? <input type="checkbox"/> Yes <input type="checkbox"/> No
Stress	Are you sexually active? <input type="checkbox"/> Yes <input type="checkbox"/> No
Hazardous Substances	Are you on birth control? <input type="checkbox"/> Yes <input type="checkbox"/> No
Heavy Lifting	If yes, what type?
Other	

What is your occupation?	(Check (✓) the disease against which you have been immunized, and approximate date:
	<input type="checkbox"/> Smallpox <input type="checkbox"/> Polio <input type="checkbox"/> Tetanus
	<input type="checkbox"/> Influenza <input type="checkbox"/> Typhoid <input type="checkbox"/> Other

I certify the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions I may have made in the completion of this form.

Signature of patient: _____ Date: _____

Signature of physician/nurse practitioner _____ Date: _____