

The Leather's Building 675 Pulaski Street Suite 1300 Athens, Georgia 30601 706-424-4219

NAME (LAST, FIRST, MIDDLE)

DATE

What are your most important health concerns?

Who is your primary care physician or OB/GYN? _____

When did you last go to a doctor's office, or hospital? What was the reason?

Medications and Supplements:

List All Medications and Supplements that you currently take and the dosages?

Please check the box for any of the following that you currently take:

- Pain relievers
- Diet pills
- Cortisone/prednisone
- Thyroid medication
- Sleeping pills
- Antacids
- Laxatives
- Tranquilizers

Allergies

Do you have allergies to foods, drugs, or other environmental allergens? Please

Explain:

Immunizations

What immunizations have you had?

- Diphtheria
- Tetanus
- Pertussis
- Measles, Mumps, Rubella
- Polio
- Chickenpox
- Shingles
- Pneumococcal
- HIB
- Cervical Cancer

Other _____

Childhood Illnesses

Have you had any of the following illnesses?

- Scarlet fever
- Diphtheria
- Rheumatic fever
- Mumps
- Measles
- Rubella
- Chicken pox
- Pertussis/Whooping cough

Occupation _____

How many children do you have? _____

- With whom do you live? Spouse
- Parents Children Friends
 - Alone Other

Habits-

Do you exercise/ How many days per week/
How long & what type of exercise

- Do you eat three meals a day? Yes No
- Awake rested? Yes No
- Sleep well? Yes No
- Do you average 6-8 hours of sleep?
 Yes No
- Enjoy your work? Yes No
- Spend time outside? Yes No
- Take vacations? Yes No
- Watch TV Yes No
- How many hours per day? _____

Read? Yes No

How many hours per day? _____

Use recreational drugs? Yes No

Use tobacco? Yes No

Use alcohol? Yes No

Have you been treated for alcoholism?

Yes No

Have you been treated for drug dependence?

Yes No

Marital Status Married Single

Separated Divorced Partnered

What are your main interests and hobbies?

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Review of Symptoms

Check any of the following you have had in the past year. Place a **P** by those you have had in the past, but do not currently have.

GENERAL

- Fatigue
- Weight Weight 1 year ago Maximum weight
- When Height

SKIN

- Rashes
- Eczema, Hives
- Acne, Boils
- Staph infections
- MRSA positive
- Itching
- Fungal Infections
- Color Change
- Hair loss
- Dry skin/scalp
- Lumps
- Night sweats
- Slow healing ulcerations
- Flushing

NOSE AND

SINUSES

- Frequent colds
- Nose bleeds
- Stuffiness
- Hay fever
- Sinus problems
- Deviated septum
- Loss of smell

EYES AND EARS

- Impaired vision
- Glasses or contacts
- Eye pain
- Itchy eyes
- Tearing or dryness

- Double vision
- Glaucoma
- Cataracts
- Impaired hearing
- Ringing
- Earache/Infections
- Dizziness

MOUTH AND THROAT

- Frequent sore throat
- Sore tongue
- Gum problems
- Teeth grinding
- Gagging/choking
- Hoarseness
- Dental cavities

HEAD & NECK

- Headache/migraine
- Faintness
- Dizziness
- Jaw Pain
- Swollen glands
- Goiter
- Pain or stiffness
- TMD

RESPIRATORY

- Cough
- Sputum
- Spitting up Blood
- Wheezing
- Asthma
- Bronchitis
- Emphysema
- Pneumonia
- Difficulty breathing
- Pain on breathing

- Shortness of breath
- Tuberculosis

CARDIOVASCULAR

- Heart disease
- Angina/chest pain
- High/low blood pressure
- Murmurs
- Blood clots
- Irregular heart beat
- Palpitations
- Swelling in ankles

CIRCULATION

- Easy bleeding or bruising
- Anemia
- Deep leg pain
- Varicose veins
- Cold hands and feet

ENDOCRINE

- Hypothyroidism
- Hyperthyroidism
- Heat or cold intolerance
- Hypoglycemia
- Diabetes
- Excessive thirst
- Excessive hunger
- Fatigue

IMMUNE

- Chronic fatigue syndrome
- Chronic infections
- Chronically swollen glands
- Slow wound healing

MUSCULOSKELETAL

- Joint pain or stiffness
- Arthritis
- Broken bones

- ___ Muscle spasms or cramps
- ___ Weakness
- ___ Osteoporosis
- ___ Restless leg syndrome
- ___ Sciatica
- ___ Chronic pain
- ___ Low back pain
- ___ Tendonitis/Bursitis

NEUROLOGIC

- ___ Seizures
- ___ Paralysis
- ___ Muscle weakness
- ___ Numbness or tingling
- ___ Easily stressed
- ___ Vertigo or dizziness
- ___ Loss of balance
- ___ Tics
- ___ Other

GASTROINTESTINAL

- ___ Heartburn/reflux
- ___ Change in thirst/appetite
- ___ Ulcer
- ___ Nausea/vomiting
- ___ Gas/bloating
- ___ Belching
- ___ Diarrhea
- ___ Constipation
- ___ Pain or cramps
- ___ Mucus in stool
- ___ Black/bloody stool
- ___ Hemorrhoids
- ___ Itching/burning anus
- ___ Rectal pain
- ___ Liver/gallbladder disease
- ___ Jaundice
- ___ IBS

- ___ Diverticulitis
- Bowel movements how often _____
- Is this a change? _____

URINARY

- ___ Pain on urination
- ___ Increased frequency
- ___ Frequency at night
- ___ Inability to hold urine
- ___ Frequent infections
- ___ Kidney stones

MENTAL/EMOTIONAL

- ___ Depression
- ___ Anxiety
- ___ Mood Swings
- ___ Tension/Stress
- ___ Bipolar
- ___ Seasonal depression

MALE ONLY

- ___ Hernias
- ___ Testicular masses
- ___ Testicular pain
- Are you sexually active?
 Yes No
- ___ Sexual difficulties
- ___ Prostate disease
- ___ Prostate cancer
- ___ Sexually transmitted infections
- ___ Discharge or sores
- Sexual preference
___ Heterosexual
___ Bisexual
___ Homosexual

FEMALE ONLY

- Age menses began _____
- Average number of days _____
- Length of cycle _____
- ___ Bleeding between periods
- ___ Cycles are regular Yes No
- ___ Pain during intercourse
- ___ Painful menses
- ___ Excessive flow
- Birth control Yes No
What type _____
- Number of pregnancies _____
- Number of live births _____
- Number of still births _____
- Number of miscarriages _____
- Number of abortions _____
- ___ Difficulty conceiving
- ___ Menopausal symptoms
- Sexually active Yes No
- ___ Sexual difficulties
- ___ Sexually transmitted infections
- Sexual preference
___ Heterosexual
___ Bisexual
___ Homosexual
- Do you do self breast exams?
 Yes No
- ___ Lumps
- ___ Pain or tenderness
- ___ Nipple discharge

I certify this information is accurate to the best of my knowledge.

Signature _____
Responsible party signs if patient is a minor

Print name _____

Date _____