

		CONF	IDENTIA	L OFFIC	E USE C	NLY			
Patient Name						t	Referring Ph	veirian:	
						[	Neierring Ph	yordan.	
Name:						Į.	Family Physi	ician:	
Name:	st	First		Middle		_ t			
Date of Birth:/_	./	Age:		Phone: _		— .			
How did you hear al	bout us? □ Phv	sician □ F	riend □ N	ewspaper	□ Other				
Please answer all ques									ning doctor.
HISTORY OF PR	ESENT ILLNE	SS:							
What problem bring	s you to this off	ice?							
Do you have a histo	orv of :	Blood Dis	ease	□ YES	□NO		When?		
		Cancer		□ YES			When?		
4-		Other		□ YES	□NO		When?		
If yes, what type?									
Prior Treatment:					X-Ray Tre		_		
Chemotherapy / Drug		□NO	When?		Skin	□YES	□NO	When?	
Radiation	□YES		When?		Thyroid	☐ YES		When?	
Surgery	□YES □YES		When?		Tonsils	LI TES	S □NO	When?	
Other			When?						
MEDICATIONS:	List all medic	ations yo	u take (p	rescripti	on and o	over the			
_ M	ledication		Dosage	т	imes Per D	ay	How Io	ng have you ta medication	ken the
							+		
							+		
							+		
							+		
Have you ever been	told to take ant	ibiotics bef	ore or after	r dental pr	ocedures	?	□ YES	□ NO	
Do you have any dr			□YES	□NO	Allergic t				
	-	-			-				
If yes, what type of	reaction?								
Joo, milat type of t									
DDIOD DI OOD TOA	NEETICIONS:	□ YES	□NO	Whoma					
PRIOR BLOOD TRA		L 1E3	2110	When?				_	
Flu YES				Honatitic	UAE6 L		en?		
	NO When?			nepatitis	LIES L	THO MI	en?		
Pneumovax	YES DNO	When?		_					



OTHER MEDICAL PR	ROBLEMS (D	iabetes, H	lypertensio	n etc.)	D	iagnosis		
	+							
Please List all hospi								
Year	Duration	Re	ason / Res	ult	<u> </u>	ospital / Phy	sician	
	1							
Additional Information								
- Additional mornadon								
Any recommended sur	rgical operatio	ns which	you have n	ot underg	one?	YES	NO	
If yes, describe:								
ii yes, describe								
		0	CCUPATIO	ONAL EX	POSURE			
Have you had exposur		O YES	CCUPATIO NO	ONAL EX	POSURE	YES	NO	WHEN
Have you had exposur		_			POSURE Agent Orange	YES	NO	WHEN
	e to:	_				YES	NO	WHEN
Asbestos	e to:	_			Agent Orange	YES	NO	WHEN
Asbestos Toxic Metals or Radioac	e to:	_	NO	WHEN	Agent Orange Worked in a Mine Lived on a Farm	YES	NO	WHEN
Asbestos Toxic Metals or Radioac	tive Material	YES	NO	WHEN	Agent Orange Worked in a Mine Lived on a Farm	YES	NO	WHEN
Asbestos Toxic Metals or Radioac Vinyl Chloride or Toxic C	tive Material Chemicals	YES	NO	WHEN	Agent Orange Worked in a Mine Lived on a Farm	YES	NO	WHEN
Asbestos Toxic Metals or Radioac Vinyl Chloride or Toxic C Marital Status If retired, last employn	tive Material Chemicals  S M	YES	SOCIA Current O	WHEN	Agent Orange Worked in a Mine Lived on a Farm ORY			
Asbestos Toxic Metals or Radioac Vinyl Chloride or Toxic C  Marital Status  If retired, last employn Do you smoke cigarett	tive Material Chemicals  S M Chemicals	YES	SOCIA Current O	WHEN  AL HISTO ccupation	Agent Orange Worked in a Mine Lived on a Farm ORY	cigarettes?	□YES	□ÑO
Asbestos Toxic Metals or Radioac Vinyl Chloride or Toxic C  Marital Status  If retired, last employn	tive Material Chemicals  S M Chemicals	YES	SOCIA Current O	WHEN  AL HISTO ccupation	Agent Orange Worked in a Mine Lived on a Farm ORY	cigarettes?		□ÑO
Asbestos Toxic Metals or Radioac Vinyl Chloride or Toxic C  Marital Status  If retired, last employn Do you smoke cigarett	tive Material Chemicals  S M  nent: tes? s per day?	YES	SOCIA Current O	AL HISTO ccupation Hav	Agent Orange Worked in a Mine Lived on a Farm ORY	cigarettes? When did y	□YES ou quit?	□ÑO
Asbestos Toxic Metals or Radioac Vinyl Chloride or Toxic C  Marital Status  If retired, last employn Do you smoke cigarett If yes, how many pack	tive Material Chemicals  S M  nent: tes? s per day?  YES	YES  D W  YES  for	SOCIA Current O	AL HISTO ccupation Hav	Agent Orange Worked in a Mine Lived on a Farm ORY n:	cigarettes? When did y	□YES ou quit?	□ÑO
Asbestos Toxic Metals or Radioac Vinyl Chloride or Toxic C Marital Status If retired, last employn Do you smoke cigarett If yes, how many pack Do you drink alcohol?	tive Material Chemicals  S M  nent: tes? s per day?  YES ar completed)	YES  D W  YES  For	SOCIA Current O	AL HISTO ccupation  Have years?	Agent Orange Worked in a Mine Lived on a Farm ORY n: e you ever smoked consumption?	cigarettes? When did y	□YES ou quit? years.	□ÑO
Asbestos Toxic Metals or Radioac Vinyl Chloride or Toxic C  Marital Status  If retired, last employn Do you smoke cigarett If yes, how many pack Do you drink alcohol?  Education (circle last year	tive Material Chemicals  S M  nent: tes? s per day?  YES ar completed)	YES  D W  YES  For	SOCIACUTENT O	Have years?	Agent Orange Worked in a Mine Lived on a Farm ORY  The you ever smoked consumption?	cigarettes? When did y for	□YES ou quit? years.	□ÑO
Asbestos Toxic Metals or Radioac Vinyl Chloride or Toxic C  Marital Status  If retired, last employn Do you smoke cigarett If yes, how many pack Do you drink alcohol? Education (circle last yes GRADE SCHOOL: 7	tive Material Chemicals  S M  nent: tes? s per day?  YES ar completed) 8 9 10 1	YES  D W  YES  For  NO  1 12	SOCIACUTE OF NO how many If yes, average COLLEGE	Have years?	Agent Orange Worked in a Mine Lived on a Farm ORY n: e you ever smoked consumption?	cigarettes? When did y for	□YES ou quit? years.	□ÑO
Asbestos Toxic Metals or Radioac Vinyl Chloride or Toxic C  Marital Status  If retired, last employn Do you smoke cigarett If yes, how many pack Do you drink alcohol? Education (circle last yes GRADE SCHOOL: 7	tive Material Chemicals  S M  nent: tes? s per day?  YES ar completed) 8 9 10 1	YES  D W  YES  For  NO  1 12	SOCIACUTE OF NO how many If yes, average COLLEGE	Have years?	Agent Orange Worked in a Mine Lived on a Farm ORY  The you ever smoked consumption?	cigarettes? When did y for	□YES ou quit? years.	□ÑO



Patient Name									
					Y HISTORY				_
				Family					Family
Diabetes		T'		Member	Tuberculosis	Y	ES	NO.	Member
Heart Disease	Ē	_			Cancer	_			
Strokes		_			Melanoma				
					Bleeding Tendency				
Anemia					Discoung ferideticy	_	_		
Kidney Disease  Additional Information									
Additional information									
,			E	AMILY M	EDICAL STATUS				
Present age				roblems or	Present age	Π		Medical pr	
or age at death	Living	Dead		of death	or age at death		Dead	cause o	f death
Father Age					Mother Age				
Brother Age					Sister Age				
	<u> </u>						<u>,</u> ,		
Significant illness in ch	nildren:								
Additional Information									
, see-viscous in a summittee									
				REVIEW	OF SYSTEMS				
	STITUT					ROLO		***	
Symptoms Weight Loss lbs	YES	NO	VVI	nen	Symptoms	YES	NO	Wh	en
					Pain, if yes see below Where / Intensity /Duration:	$\vdash$			
Weight GainIbs						<u> </u>			
Chills or Fever	ᅳ				Headaches				
Fatigue					Insomnia				
Night Sweats					Seizures-Epilepsy				
Are you up most of the day?					Memory Defect				
In bed more than half					The state of the s				
the time?					Balance Problems				
Left Handed	F	Right H	landed		Difficulty Walking in the Dark				
EYES, EARS,	NOSE,	THRO	AT, MOUTH	ł	Numbness & Tingling Extremities				
SYMPTOMS	YES	NO	W	nen	Shaking or Tremor of Hands				
Eye Surgery Cataracts					Additional symptoms:				
Glaucoma					ľ				
Vision Change									
Double Vision									
Hearing Loss									
Ear Aches					I				
Difficulty Swallowing					ľ				
	_				l.				
Sinus Infections		一			†				
Sinus Infections Sore Throats	_								



Patient Name			_,				
			CARDIO	OVASCULAR			
Have you had:	YES	NO	When		YES	NO	When
Shortness of Breath with Exercise	l□			Rheumatic Fever	l		
Ankle Swelling	H	+		Stroke or Paralysis	ᅡ	ᆂ	
High Blood Pressure	H	岩		Circulation Problems		計	
Rapid Heart Beat	┝	岩		Heart Attack		岩	
Dizziness	H	-		Heart Murmur		ᆉ	
Fainting Spells	H	뮈		Heart Valve Problem	H	井	
Chest Pain or Pressure-				neart valve Problem	-		
Angina				Heart Infection			
Leg Cramps				Sleep onpillows			
Additional Information							
Have you had:	YES	NO	When RES	PIRATORY	YES	NO	When
Tuberculosis			Wileii	Emphysema			Wilen
i apoliogiosis	┝┶一			Shortness of Breath	┝╩┈		
Coughed up Blood				at Night			
Asthma or Wheezing				Pleurisy			
Bronchitis				Pneumonia			
Sputum Production				Blood Clot in Lung			
Additional Information				•			
			CASTR	OINTESTINAL			
Have veri hadi	VEC	110		OINTESTINAL	VEC	NO	Miles
Have you had: Increased Appetite	YES	NO	When	Abdominal Swelling	YES	NO	When
increased Appende				Change in Bowel			
Decreased Appetite				Movement			
Nausea and Vomiting				Constipation			
Abdominal Pain or							
Cramps				Diarrhea Blood in Bowel	╙	ᆜ	
Ulcer Disease				Movement			
Yellow Jaundice-	┝╧┈			Black Bowel	Н—	_	
Hepatitis				Movement			
Liver Disease-Cirrhosis				Diverticulitis			
Gall Bladder Problem -		$\neg \neg$		O mir			
Gallstone	ᅳ	무늬		Colitis	믐	井	
Pancreatic Disease				Hemorrhoids			
Additional Information							



				FEMALE			
Have you had:	YES	NO	When	Have you had:	YES	NO	When
History of Menstrual					_		
Irregularity				Breast Discharge			
Vaginal Bleeding Currently	_	_		Broost Swalling		$\neg$ I	
Use of Hormones during				Breast Swelling		<u> </u>	
Menopause		<u> </u>		Breast Pain			
Breast Fed Infant	6			Breast Mass		$\exists$	
Age at Menopause		_					
Age of first Menses				Breast Biopsy			
(Period)				Abnormal Mammogram			
Number of times		<del></del>		Tanoma maminogram	<del>-</del>	_	
Pregnant				Vaginal Discharge			
Number of Live Births				Pelvic Pain			
Age at first Delivery		$\overline{}$		D&C			
Means of Birth Control		<del>-</del> -		Hysterectomy			
Last Menstrual Period		$\frac{1}{1}$		Removal of Ovaries			
		+		Removal of Ovaries			
Last Mammogram				$\dashv$			
Last Pap Smear  Additional Information							
INTEGU		ULT 120	in).		PSYC	HAIRIC	
<u>INTEGU</u> Have you had:	YES	NO	When	Have you had:	YES	NO NO	When
Have you had:				Have you had: Depression			When
Have you had:	YES	NO			YES	NO	When
Have you had: Red / Blot Areas Dark Moles	YES	NO 🗆		Depression	YES	NO 🗆	When
Have you had: Red / Blot Areas	YES	NO		Depression	YES	NO 🗆	When
Have you had: Red / Blot Areas Dark Moles Rash / Itching	YES	NO		Depression	YES	NO 🗆	When
Have you had: Red / Blot Areas Dark Moles Rash / Itching	YES	NO		Depression	YES	NO 🗆	When
Have you had: Red / Blot Areas Dark Moles Rash / Itching	YES	NO		Depression	YES	NO 🗆	When
Have you had: Red / Blot Areas Dark Moles Rash / Itching Additional Information	YES	NO		Depression	YES	NO 🗆	When
Have you had: Red / Blot Areas Dark Moles Rash / Itching Additional Information	YES	NO		Depression	YES	NO 🗆	When
Have you had: Red / Blot Areas Dark Moles Rash / Itching Additional Information	YES	NO	When	Depression	YES	NO 🗆	When
Have you had: Red / Blot Areas Dark Moles Rash / Itching Additional Information  Notes  Did someone other tha	yes	nt comp	When	Depression  Mood Swings	YES	NO	When
Have you had: Red / Blot Areas Dark Moles Rash / Itching Additional Information  Notes  Did someone other tha	yes	nt compliant:	When	Depression  Mood Swings	YES	NO	When



Do you currently smoke	No	Yes	GASTROINTESTINAL:			within the last 30 days below Falls		Yes
Former smoker	No	Yes	Abdominal pain	No	Yes	Frequent headaches	No	Yes
Have you had the Flu Vaccine	No	Yes	Blood in stool	No	Yes	Memory loss	No	Yes
Pneumococcal Vaccine	No	Yes	Constipation	No	Yes	Numbness location	No	Yes
CONSTITUTIONAL SYMPTOMS:	14.5	****	Diarrhea	No	Yes	Pain Location:		Yes
Chills	No	Yes	Hepatitis Kind: A B C	No	Yes	1 - 10, with 10 being the worst	-	
Fatigue	No		The state of the s	No	Yes	1 2 3 4 5 6 7 8 9 10		
Fever	No			No	Yes	Selzures	No	Yes
Weight loss, unintentional	No	Yes	Vomiting	No	Yes		No	Yes
Weight gain, unintentional	No			1	1	Syncope	No	Yes
EYES:	1	3	Burning or painful urination	No	Yes	Tingling location	No	Yes
Blurred vision	No	Yes		No	Yes	Tremors	No	Yes
Corrective lenses	No			No	Yes	Visual Changes	No	Yes
Double vision	No			No	Yes	PSYCHIATRIC:		-
EARS/NOSE/MOUTH/THROAT:			Incontinence	No	Yes	Anxiety	No	Yes
Earaches	No	Yes	Frequent urination	No	Yes	Depression	No	Yes
Nose bleeds	No		Male Penile Discharge	No	Yes	Sleep Disorder	No	Yes
Bleeding gums	No	Yes	Male Scrotal Swelling	No	Yes	Trouble falling asleep	No	Yes
Hearing loss	No	Yes		No	Yes	Trouble staying asleep	No	Yes
Mouth sores	No	Yes	Male Testicular pain	No	Yes			
Sore throat	No	Yes		No	Yes	Intolerance to cold	No	Ye
Ringing in the ears	No	Yes	Female Super Pubic Pain	No	Yes		No	Ye
CARDIOVASCULAR:	1		Female Vaginal discharge	No	Yes		No.	Ye
Chest pain	No	Yes	MUSCULOSKELETAL:			Excessive thirst	No	Ye
Palpitations	No	Yes	Arthralgia/Joint pain	No	Yes	The state of the s	No	Ye
Swelling of feet, ankles, or hands	No	Yes	Back pain	No	Yes			_
Location			Joint stiffness	No	_		No	Ye
RESPIRATORY:			Muscle weakness	No			No	Ye
Chronic or frequent cough	No	Yes	Muscle pain	No	Yes		No	Ye
Shortness of breath	No	Yes		,		Easy bruising	No	Ye
Spitting up blood	No	Yes		No			No	Ye
Wheezing	No	Yes		No			-	4.
BREAST:		1	Rash	No		A STORY TO LOCATE AND A STORY OF THE STORY O	No	
Axillary Pain	No	-	10 100 combar in 10 10 10 10 10 10 10 10 10 10 10 10 10	No	Ye		No	_
Breast Lump	No					Painful glands	No	Ye
Breast Tenderness	No	_		No	_		+	+
Nipple discharge	No	Yes	Dizziness	No	Ye	S		

Current medications:							
Name of medication	Strength of medication	Frequency of medication					
	***						
	d						



Patient Name GENITOURINARY Have you had: YES NO When YES NO When Urinate during the night How Frequent Urination 1 П many times Painful Urination П П Blood in Urine Pain in Testicles (men) Cystitis Prostate Problems (men) П Incontinence Loss of Sexual Potency (men) Kidney Stone Swelling of Breast (men) Hernia Hard to Start Urine (men) Bloody or Other Discharge Testicular Mass (men) Venereal Disease Decreased Urine Flow (men) Additional Information MUSCULOSKELETAL Have you had: YES When YES When NO NO Arthritis-Type Osteoporosis Muscle Pain or Cramps Joint Replacement  $\Box$ Painful or Swollen Joints History of Fracture П Lupus Loss of Limb  $\square$ П  $\Box$ П Gout Bone Disease Backaches П П Laminectomy-Disc Disease Additional Information **ENDOCRINE HEMATOLOGY** Have you had: YES NO When Have you had: YES NO When Tendency to Bleed or Bruise Thyroid Disease Heat Intolerance Lymph Node Enlargement Frequent Nose Bleed Bleeding after Tooth Bleeding after Tooth Extraction Extraction Diabetes П White Blood Cell Problem Adrenal Disease  $\Box$ П Platelet Problem Hair Loss or Gain Anemia Voice Change History of Leukemia Abnormal Spleen Salt Loss or Water Blood Clots; Treatment Retention Additional Information