

PET/CT • CT • DIGITAL MAMMOGRAPHY • BONE DENSITY • ULTRASOUND
LUNG CANCER SCREENING • CARDIAC SCORING

MEDICAL HISTORY

Name: _____ DOB: _____ Single Divorced
Married Widow(er) Date: _____

Address: _____ Occupation: _____

Have you traveled outside the USA in the last year? Yes No Where: _____

REASON FOR TODAY'S APPOINTMENT: _____

Were you referred to the clinic? Yes No If so, by whom: _____

FAMILY HISTORY	If Living		Age at Death	If Deceased Cause	Has any blood Relative ever had:	Please Circle Answer	
	Age	Health				no	yes
Father					Cancer	no	yes
Mother					Tuberculosis	no	yes
Brother or Sister	1.				Diabetes	no	yes
	2.				Heart Trouble	no	yes
	3.				High Blood Pressure	no	yes
	4.				Stroke	no	yes
	5.				Epilepsy	no	yes
					Mental Illness	no	yes
Husband / Wife					Suicide	no	yes
Son or Daughter	1.				Birth Defects	no	yes
	2.				Thyroid Disease	no	yes
	3.				Alcoholism	no	yes
	4.						
	5.						
	6.						

PERSONAL HISTORY (Please circle all answers, yes or no.)

ILLNESSES: Have you ever had

Measles or German Measles	yes	no	Ulcers (stomach or intestinal)	yes	no	Angina	yes	no
Chicken pox or Mumps	yes	no	Hepatitis or Jaundice	yes	no	Heart Failure	yes	no
Whooping cough	yes	no	Gallbladder Disease	yes	no	Rheumatic fever/murmur	yes	no
Scarlet fever or Scarletina	yes	no	Hiatus hernia	yes	no	High blood pressure	yes	no
Migraine headaches	yes	no	Diverticulosis	yes	no	High cholesterol	yes	no
Stroke or paralysis	yes	no	Kidney Stones or Kidney Failure	yes	no	Diabetes	yes	no
Blindness (even temporary)	yes	no	Bright's Disease	yes	no	Thyroid disease/goiter	yes	no
Seizures or epilepsy	yes	no	Kidney or Urinary tract infections	yes	no	X-ray Therapy / Radiation	yes	no
Meningitis or polio	yes	no	Venereal Disease	yes	no	Nervous Breakdown	yes	no
Pneumonia or pleurisy	yes	no	Gonorrhea or Syphilis	yes	no	Severe Depression	yes	no
Tuberculosis	yes	no	Arthritis or Rheumatism	yes	no	Frequent sore throats	yes	no
Asthma	yes	no	Bursitis, Sciatica, Lumbago	yes	no	Frequent infections	yes	no
Influenza or flu	yes	no	Neuritis or Neuralgia	yes	no	Any other disease:	_____	
Hayfever	yes	no	Anemia	yes	no			
Hives or eczema	yes	no	Unusual bleeding or Bruising	yes	no			
Heart Attack	yes	no	Poisoning (food, chemicals, drugs)	yes	no			

Have You Ever Been Immunized For (Circle yes or no)

Diphtheria	yes	no	when:_____	Pneumonia	yes	no	when:_____
Tetanus	yes	no	when:_____	Influenza	yes	no	when:_____
Polio	yes	no	when:_____	Measles	yes	no	when:_____
German Measles	yes	no	when:_____	Whooping Cough	yes	no	when:_____

Have you ever had a skin test for TB (tuberculosis)? yes no When:_____

ALLERGIES: Are you allergic to:

Penicillin or Keflin	yes	no	Iodine, Merthiolate, or Mercurochrome	yes	no
Sulfa	yes	no	Betadine or pHisoHex	yes	no
Erythromycin or Tetracycline	yes	no	Antihistamines	yes	no
Any other antibiotics	yes	no	Any other drug	yes	no
Aspirin or Tylenol	yes	no	Any Food	yes	no
Codeine or Morphine or Demerol	yes	no	Adhesive tape	yes	no
Any other pain medication	yes	no	Cosmetics or perfume	yes	no
Valium or Librium	yes	no	Nail polish	yes	no
Phenobarbital	yes	no	Tetanus antitoxin shots	yes	no
Dalmane or Seconal	yes	no	Any other immunizations	yes	no
Any other tranquilizer/sleeping medications	yes	no	Any other serums	yes	no

INJURIES: Have you had any:

Broken bones	yes	no	Sprains or dislocations	yes	no
Lacerations (extensive)	yes	no	Concussion or head injury	yes	no
Ever been knocked out	yes	no	Whiplash	yes	no

TRANSFUSIONS: have you ever had

Blood or Plasma transfusion yes no

WEIGHT: Now _____ one year ago _____

Maximum _____ year _____

HOSPITALIZATIONS:

Surgical Hospitalizations:

- (1) Tonsillectomy
- (2) Appendectomy
- (3) Any other surgery (Please List)

Hospitalizations other than for surgery:

- (1) _____
- (2) _____
- (3) _____
- (4) _____

HABITS: Do you

Sleep well?	yes	no
Use alcoholic beverage?	yes	no
Everyday?	yes	no
Smoke?	yes	no
How much? _____		
Exercise enough?	yes	no
Is your diet well balanced?	yes	no

MEDICATIONS: List any drug or medication that you take.

WOMEN ONLY:

Age at onset of menstruation: _____

Date of last period: _____

Is it possible that you may be pregnant? yes no

Menstrual cycle _____ days (from start to start)

Cycle: regular or irregular

Usual duration of flow _____ days

Flow: heavy medium light

Cramps: severe mild none

Pregnancies:

How many? _____

Children born alive? _____

Stillbirth? _____

Premature? _____

Cesarean sections? _____

Miscarriages? _____

Complications? yes no

SYSTEMS REVIEW:

Please check any of the problems that apply to you.

General:

- Fatigue
- Weakness
- Fever

Nervous:

- Headaches
- Dizziness
- Fainting
- Muscle Spasm
- Loss of consciousness
- Sensitivity/pain in hands
- Memory loss

Ears:

- Ringing in ears
- Loss of hearing

Eyes:

- Pain
- Redness
- Loss of vision
- Double/blurred vision
- Dryness

Nose:

- Nosebleeds
- Loss of smell
- Dryness

Mouth:

- Sore tongue
- Bleeding gums
- Sores in mouth
- Loss of taste
- Dryness

Blood:

- Bleeding tendency

Throat:

- Hoarseness

Neck:

- Swollen glands
- Tender glands

Heart/Lungs:

- Pain in chest
- Irregular heart beat
- Sudden changes in heart beat
- Shortness of breath
- Difficulty breathing at night
- Swollen legs/feet
- High blood pressure
- Heart murmur
- Cough
- Coughing blood
- Wheezing
- Night sweats

Kidney/Urine/Bladder:

- Difficulty urinating
- Pain/burning
- Blood in urine
- Cloudy urine
- Pus in urine
- Discharge from penis/vagina
- Frequent urination
- Getting up at night to urinate
- Vaginal dryness
- Sexual difficulties
- Prostate trouble

Skin:

- Bruise easy
- Redness
- Rash
- Hives
- Tightness
- Nodules/Bumps
- Hair loss
- Color changes of the hands or feet

Muscles/Joints/Bones:

- Joint pain
- Muscle weakness
- Muscle tenderness
- Joint swelling