PATIENT ID: Name: (Last, First, MI) _____DOB (MMDDYY) _____ Sex: M or F

Duty Phone(with prefix): _____ Cell Phone(with prefix): _____

Home #: _____Email: _____APO Address_____

SPONSOR'S INFORMATION: Social Security Number:_____ - Unit/Location: _____

Rank/GS series:_____ Service: (Army)(Air Force)(Navy)(Marines)(DoD)(Other) Duty Phone: _____

Sponsor Cell: _____ Sponsor's Email:_____

PERSONAL MEDICAL HISTORY: Please circle any/all that apply

Anesthesia problems
Alcoholism / other addiction
Allergies (environmental)
Anxiety/Depression
Asthma / COPD
Atrial fibrillation
Cancer (specify type _____)
Coagulation (bleeding or clotting) problem
Heart disease (specify type_____)
Hypertension (high blood pressure)
Stroke
Hepatitis
Diabetes mellitus
Thyroid problem
Chronic low back pain
Sleep Apnea
Cholesterol problem
Other problems (list):_____
_____

Illnesses – Please list major illnesses/when?

Surgeries -Please list any surgical procedures/dates

Medications –Prescription and non-prescription medicines, vitamins, birth control pills, herbs; please continue medications on the other side: □ I take no regular medications. Do you take **Aspirin** or **other blood thinners**? Yes No

Medication	How Much/How Often	Medication	How Much/How Often

Allergies – Please list all **MEDICATION** allergies

Social History: Occupation:_____ Marital Status: _____

Smoking Y N I smoke(d) ___ packs/day for _____yrs **OR** I quit ____yrs ago
Alcohol Y N I have _____ drinks/day **OR** I drink socially (< 3 drinks/week)
Caffeine Y N How much per day?_____

Family History

Father:	
Mother:	
Anesthesia Problems?	
Prolonged bleeding?	

Have you ever had a blood transfusion? Y N Explain_____

PLEASE LIST THE REASON FOR YOUR VISIT TODAY:_____

WOULD YOU LIKE A CHAPARONE FOR YOUR EXAM? Initial: _____ YES/NO

REVIEW OF SYMPTOMS: Please check (✓) any current problems you have on the list below.

Constitutional
___Fevers/chills/sweats
___Unexplained weight loss/gain
___Fatigue/weakness

Eyes
___Change in vision

E ars/Nose/Throat/Mouth
___Difficult hearing/Ringing in ears
___Problems with teeth/gums
___Hay fever/allergies

Respiratory
___Cough/wheeze
___Difficulty breathing

Cardiovascular
___Chest pain/discomfort
___Leg pain with exercise
___Palpitations

Gastrointestinal
___Abdominal pain
___Bloody/black bowel movement
___Nausea/vomiting/diarrhea
___Constipation

Genitourinary
___Nighttime urination
___Leaking urine
___Painful urination
___Blood in urine
___Unusual vaginal bleeding
___Sexual function problems

Musculoskeletal
___Muscle/joint pain or swelling

Endocrine
___Excessive thirst or urination

Neurological
___Headaches
___Dizziness/light-headedness
___Numbness
___Memory loss
___Loss of coordination

Psychiatric
___Anxiety/stress
___Problems with sleep
___Depression

Skin
___Rash or mole change

Blood/Lymphatic
___Unexplained lumps
___Easy bruising/bleeding
___Sickle cell disease

For Women: # pregnancies:____ # deliveries:____ # abortions: ____ # miscarriages: _____
1st day, most recent period: _____ Age at 1st period:____ Frequency of periods:_____ Length of each: _____
Have you ever had an abnormal PAP test? Y N Any concerns about menopause/periods? Y N _____