

Susan M. Felber, M.D., S.C.

Internal Medicine

Name: _____

DOB: _____

Reason for visit today:

Emergency contact name (and relation to patient) and phone #: _____

ALLERGIES:

MEDICATIONS (PRESCRIPTION & OVER THE COUNTER MEDICINE) INCLUDE NAME, DOSAGE & FREQUENCY:

1.	8.
2.	9.
3.	10.
4.	11.
5.	12.
6.	13.
7.	14.

MEDICAL CONDITIONS, ILLNESSES, INJURIES, HOSPITALIZATIONS

PROBLEM/DATE	PROBLEM/DATE	PROBLEM/DATE

Have you had a transfusion of blood or blood products? Yes No If yes did you have any reaction? Yes No

PERSONAL & SOCIAL HISTORY

ALCOHOL/TOBACCO/DRUGS RISK SCREEN:

- Do you use cigarettes, pipes, cigars or chew tobacco? Yes No
- Do you drink alcohol? Yes No If, yes answer questions below.
- Ever tried to cut back on the amount of alcohol you drink? Yes No
- Ever become angry when people discuss your alcohol? Yes No
- Ever felt guilty about anything you did because of your drinking? Yes No
- Ever had a drink before noon (eye opener)? Yes No
- Has your drinking affected your relationship with your family or friends? Yes No
- Has your drinking affected your work or school? Yes No
- Have you ever drunk alcohol while or before driving or driven while intoxicated? Yes No
- Do you drink coffee, sodas or other caffeinated beverages? Yes No
- Do you use any street drugs or abuse prescription pain medication? Yes No

SOCIAL HISTORY

- Do you think you are at risk for HIV, AIDS or other sexually Transmitted disease? Yes No
- Do you exercise? Yes No Frequency: _____
- If yes, when ____/____. What was the Result? _____
- Marital status: Married Single Divorced Widow(er) Separated
- Education: Jr. High School High School/GED Vocational School College Other: _____
- Occupation: _____ Do you have an Advance Directive? Yes No

FAMILY HISTORY

FAMILY MEMBER	AGE	ALIVE / DECEASED	HEALTH	CAUSE OF DEATH
Father		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
Mother		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
1. <input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		
2. <input type="checkbox"/> Brother <input type="checkbox"/> Sister		<input type="checkbox"/> Alive <input type="checkbox"/> Deceased		

More questions on back.

Please turn over

FAMILY HISTORY		RELATIVE			RELATIVE
1. Alzheimer's Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	11. Iron Storage Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
2. Breast Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	12. High Blood Pressure	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
3. Heart Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	13. Ovarian Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
4. Stroke	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	14. Prostate Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
5. Depression, Suicide	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	15. Skin Cancer	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
6. Diabetes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	16. Thyroid Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
7. High Cholesterol	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	17. Sickle Cell Disease	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
8. Obesity	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	18. Anemia	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
9. Glaucoma	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	19. Macular degeneration	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____
10. Substance Abuse	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	20. Other:		_____

HEALTH MAINTENANCE

Last Stools, occult blood test: ____/____ Colonoscopy/Sigmoidoscopy: ____/____

Dental Exam: ____/____ Dilated Eye Exam: ____/____ Foot Exam: ____/____

WOMEN: Last: PAP smear: ____/____ Mammogram: ____/____ Breast Exam: ____/____ Menstrual Period: ____/____/____

MEN: Last: Rectal/Prostate exam: ____/____ Testicular Exam: ____/____ PSA: ____/____

IMMUNIZATIONS: (last date/year received) Tetanus: _____ Hepatitis B vaccine: _____ MMR: _____

Pneumonia: _____ Flu: _____ Tuberculosis Skin Test (date & results): _____

Please review the list of symptoms below.

Check "Yes" box if you suffer from the symptoms or have any of the health issues listed in the past 6 months Check "No" box if you do not.

<p>CONSTITUTIONAL</p> <p>Unexplained weight loss <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Unexplained weight gain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fevers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chills <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fatigue <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nausea or Vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Eyes</p> <p>Cataract <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Change in vision <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Glasses <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Red eyes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>ENMT</p> <p>Bleeding from gums <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems hearing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Change in your voice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Denture <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nose bleeds <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hoarse voice <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sinus problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Ringing in ears <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Mouth ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>CARDIOVASCULAR</p> <p>Angina <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart problems <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Chest pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Leg pain with walking <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems with exercise <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swelling in legs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems lying flat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Skipping heart beats <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Short of breath at night <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>RESPIRATORY</p> <p>Bronchitis <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cough <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Coughing up blood <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Shortness of Breath <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Wheezing <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>SKIN</p> <p>Skin changes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Skin lesions <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Skin itching <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Rashes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dry skin <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>GASTROINTESTINAL</p> <p>Blood in stool <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Change in movements <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Constipation <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Diarrhea <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Difficulty swallowing <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Heart burn <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hemorrhoids <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Black tarry stool <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Nausea or vomiting <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Stomach Ulcers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>GENITOURINARY</p> <p>Problems urinating <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Blood in urine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hernias <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Incontinence <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Urination at night <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Sexual transmitted Dz. <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Urinary urgency <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>WOMEN ONLY</p> <p>Problems with your period <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Vaginal dryness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems with sex <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Vaginal discharge <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain in breast <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Lumps in breast <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Breast discharge <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>MEN ONLY</p> <p>Problems with erections <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dribbling of urine <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weak urine stream <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Pain in testicles <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p>MUSCULAR SKELETAL</p> <p>Neck pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Gout <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Injury to limbs <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint Pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Joint stiffness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Locking joints <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Back pain <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Red or Swollen in joints <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>HEMATOLOGY/ONCOLOGY</p> <p>Anemia or low blood <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Easily bruise <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swollen lymph nodes <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Cancers <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>PSYCHIATRIC</p> <p>Depression or Sadness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Feel like hurting someone <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Feel like hurting yourself <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems with memory <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Anxiety <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems concentrating <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems sleeping <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>NEUROLOGY</p> <p>Change in memory <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Dizziness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Headaches <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Imbalance <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Numbness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Weakness <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tremors <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Seizures <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>ENDOCRINE</p> <p>Problems with heat <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Problems with cold <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Swelling in neck <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Frequent urination <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Excessive thirst <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Changes in hair <input type="checkbox"/> Yes <input type="checkbox"/> No</p>
--	--	---

Print Name & Sign

Date

Physician Signature & Date