Confidential

Patient Name_____Today's Date:_____

Age_____Birth date:_____Last Physical /Blood Work:_____

What is your reason for your visit today? ☐ Weight Management ☐ Fatigue ☐ Preventive Health ☐ Other

Symptoms *(Please check all that apply)*

General:
- ☐ Chills
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of Weight
- ☐ Low Body Temp.
- ☐ Nervousness
- ☐ Numbness
- ☐ Sweats

Muscle/Joint/Bone:
Pain, weakness or numbness in:
- ☐ Arms ☐ Hips
- ☐ Back ☐ Legs
- ☐ Feet ☐ Neck
- ☐ Hands ☐ Shoulders

Genito-Urinary:
- ☐ Blood in urine
- ☐ Frequent urination
- ☐ Lack of bladder control
- ☐ Painful urination

Gastrointestinal:
- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Hunger
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Sensitive Stomach
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Cardiovascular:
- ☐ Chest Pain
- ☐ High Blood Pressure
- ☐ Irregular Heart Beat
- ☐ Low Blood Pressure
- ☐ Poor Circulation
- ☐ Rapid Heart Beat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Eye/Ear/Nose/Throat:
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Cataracts
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleeds
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision-Flashes
- ☐ Vision-Halos

Skin:
- ☐ Bruise easily
- ☐ Hives
- ☐ Itching
- ☐ Change in Moles
- ☐ Rash
- ☐ Scars
- ☐ Sore that won't heal

Men Only:
- ☐ Breast lump
- ☐ Erection Difficulties
- ☐ Lump in testicles
- ☐ Penis Discharge
- ☐ Prostate Problems
- ☐ Sore on Penis
- ☐ Other:_____

Women Only:
- ☐ Abnormal Pap Smear
- ☐ Bleeding between periods
- ☐ Breast lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Miscarriage
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Vaginal Infections
- ☐ Other:_____

Date of Last Menstrual Period:_____

Date of Last Pap Smear:_____

Have you had a Mammogram?_____

Are you pregnant?_____

Number of children:_____

Conditions:
- ☐ Aids
- ☐ Alcoholism
- ☐ Anemia
- ☐ Anorexia/Bulimia
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorders
- ☐ Cancer
- ☐ Chemical Dependency
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gastric Reflux
- ☐ Glaucoma
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Other:_____
- ☐ _____
- ☐ _____
- ☐ _____

Medications: (Please list all medications you are currently taking)

_____
_____
_____
_____
_____

Allergies:_____
_____
_____
_____
_____

Pharmacy
Name:_____Phone:_____

Hospitalizations

Please list any major surgeries you have had:

_____
_____
_____
_____
_____
_____
_____

Family History: Check if any of your blood relatives have had any of the following:

- ☐ Cancer
- ☐ Diabetes
- ☐ Heart Disease/Stroke
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Obesity

Occupation:_____

Check if your work exposes you to the following:

- ☐ Stress
- ☐ Heavy Lifting
- ☐ Hazardous Substances
- ☐ Other

Health Habits:

Of sodas you consume per day:_____

Do you smoke cigarettes?_____

If yes, how many packs per day?_____

Weekly alcohol intake:_____

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform Dr. Bartemus or his staff, if I, or my minor child, ever have any changes in health.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Printed Name of Patient, Parent, Guardian or Personal Representative Relationship to Patient

_____ _____
Reviewed by Date

Health History