

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

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

- 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

- 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: _____

Muscle/Joint/Bone:

- Pain, weakness or numbness in:
- Arms Hips
 - Back Legs
 - Feet Neck
 - Hands Shoulders

Cardiovascular:

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

Skin:

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

Date of Last Menstrual Period: _____
Date of Last Pap Smear: _____
Have you had a Mammogram? _____
Are you pregnant? _____

Number of children: _____

Genito-Urinary:

- Blood in urine
- Frequent urination
- Lack of bladder control
- Painful urination

Eye/Ear/Nose/Throat:

- Bleeding Gums

Men Only:

- Breast lump

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