225 Candler Drive, Suite 201 • Savannah, GA 31405
(912) 692-2000 • Fax (912) 692-2100

Date ____________________

Patient Name ____ Age ____________

Referred By ____

History

Chief Complaint: ____

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____

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Past Medical History

Hypertension	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
High Cholesterol	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Heart Trouble	☐ No	☐ Yes
Arthritis/Gout	☐ No	☐ Yes
Convulsions	☐ No	☐ Yes
Bleeding Tendency	☐ No	☐ Yes
Acute Infections	☐ No	☐ Yes
Hereditary Defects	☐ No	☐ Yes
Cancer	☐ No	☐ Yes

Previous Hospitalizations/Surgeries/Serious Injuries — When?

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Medications

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Marital Status	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed
Use of Alcohol	☐ Never	☐ Rarely	☐ Moderate	☐ Daily	
Use of Tobacco	☐ Never	☐ Previously but quit		☐ Current	packs/day ________
Use of Drugs	☐ Never	☐ Type / Frequency: ________			
Excessive exposure at home or work to:	☐ Fumes	☐ Dust	☐ Solvents	☐ Air Borne Particles	

Occupation ____

Family Medical History

	Age	Disease	if Deceased, Cause of Death
Father			
Mother			
Siblings			
Spouse			
Children			

Constitutional Symptoms		
Good general health lately	☐ No	☐ Yes
Recent weight change	☐ No	☐ Yes
Fever	☐ No	☐ Yes
Fatigue	☐ No	☐ Yes
Night Sweats	☐ No	☐ Yes
Eyes		
Eye disease or injury	☐ No	☐ Yes
Wear glasses/contact lenses	☐ No	☐ Yes
Blurred or double vision	☐ No	☐ Yes
Glaucoma	☐ No	☐ Yes
Cataracts	☐ No	☐ Yes
Ears, Nose, Mouth and Throat		
Hearing loss or ringing	☐ No	☐ Yes
Earaches or drainage	☐ No	☐ Yes
Chronic sinus problem or rhinitis	☐ No	☐ Yes
Frequent nose bleeds	☐ No	☐ Yes
Mouth sores	☐ No	☐ Yes
Bleeding gums	☐ No	☐ Yes
Periodontal disease	☐ No	☐ Yes
Swollen glands in neck	☐ No	☐ Yes
Trouble with teeth	☐ No	☐ Yes
Cardiovascular		
Chest pain	☐ No	☐ Yes
Irregular heart beat	☐ No	☐ Yes
Shortness of breath with walking or lying flat	☐ No	☐ Yes
Swelling of feet, ankles or hands	☐ No	☐ Yes
High blood pressure	☐ No	☐ Yes
Cramps in legs while walking	☐ No	☐ Yes
Respiratory		
Chronic or frequent coughs	☐ No	☐ Yes
Spitting up blood	☐ No	☐ Yes
Shortness of breath	☐ No	☐ Yes
Asthma or wheezing	☐ No	☐ Yes
Pneumonia	☐ No	☐ Yes
Gastrointestinal		
Loss of appetite	☐ No	☐ Yes
Change in bowel movements	☐ No	☐ Yes
Nausea or vomiting	☐ No	☐ Yes
Frequent diarrhea	☐ No	☐ Yes
Painful bowel movements or constipation	☐ No	☐ Yes
Rectal bleeding or blood in stool	☐ No	☐ Yes
Abdominal pain or heartburn	☐ No	☐ Yes
Peptic ulcer (stomach or duodenal)	☐ No	☐ Yes
Jaundice	☐ No	☐ Yes
Hepatitis	☐ No	☐ Yes
Cirrhosis	☐ No	☐ Yes
Genitourinary		
Frequent urination	☐ No	☐ Yes
Burning or painful urination	☐ No	☐ Yes
Blood in urine	☐ No	☐ Yes
Change in force of strain when urinating	☐ No	☐ Yes
Incontinence or dribbling	☐ No	☐ Yes
Kidney stones	☐ No	☐ Yes
Sexual difficulty	☐ No	☐ Yes
Male - testicle pain	☐ No	☐ Yes
Female - pain with periods	☐ No	☐ Yes
Female - irregular periods	☐ No	☐ Yes
Female - vaginal discharge	☐ No	☐ Yes
Female - # of pregnancies	☐ No	☐ Yes

Genitourinary (continued)		
Female - # of miscarriages	☐ No	☐ Yes
Female - date of last pap smear	______	
Musculoskeletal		
Joint pain	☐ No	☐ Yes
Joint stiffness or swelling	☐ No	☐ Yes
Weakness of muscles or joints	☐ No	☐ Yes
Muscle pain or cramps	☐ No	☐ Yes
Back pain	☐ No	☐ Yes
Cold extremities	☐ No	☐ Yes
Difficulty in walking	☐ No	☐ Yes
Arthritis	☐ No	☐ Yes
Integumentary (skin, breast)		
Rash or itching	☐ No	☐ Yes
Change in skin color	☐ No	☐ Yes
Change in hair or nails	☐ No	☐ Yes
Moles/skin cancer	☐ No	☐ Yes
Skin disease	☐ No	☐ Yes
Breast pain	☐ No	☐ Yes
Breast lump	☐ No	☐ Yes
Breast discharge	☐ No	☐ Yes
Neurological		
Frequent or recurring headaches	☐ No	☐ Yes
Light headed or dizzy	☐ No	☐ Yes
Convulsions or seizures	☐ No	☐ Yes
Numbness or tingling sensations	☐ No	☐ Yes
Tremors	☐ No	☐ Yes
Paralysis	☐ No	☐ Yes
Stroke	☐ No	☐ Yes
Head injury	☐ No	☐ Yes
Psychiatric		
Memory loss or confusion	☐ No	☐ Yes
Nervousness/Anxiety	☐ No	☐ Yes
Depression	☐ No	☐ Yes
Insomnia	☐ No	☐ Yes
Endocrine		
Glandular or hormone problem	☐ No	☐ Yes
Thyroid disease	☐ No	☐ Yes
Diabetes	☐ No	☐ Yes
Excessive thirst or urination	☐ No	☐ Yes
Heat or cold intolerance	☐ No	☐ Yes
Skin becoming drier	☐ No	☐ Yes
Change in hat or glove size	☐ No	☐ Yes
Hematological/Lymphatic		
Slow to heal after cuts	☐ No	☐ Yes
Bleeding or bruising tendency	☐ No	☐ Yes
Anemia	☐ No	☐ Yes
Phlebitis	☐ No	☐ Yes
Past transfusion	☐ No	☐ Yes
Enlarged glands	☐ No	☐ Yes
Allergic/Immunologic		
History of skin reaction or other adverse reaction to:		
Penicillin or other antibiotics	☐ No	☐ Yes
Morphine, Demerol, or other narcotics	☐ No	☐ Yes
Novocaine or other anesthetics	☐ No	☐ Yes
Aspirin or other pain serums	☐ No	☐ Yes
Tetanus antitoxin or other serums	☐ No	☐ Yes
Iodine, methlolate or other antiseptic	☐ No	☐ Yes

Other drugs/medications: ______________________________

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Known food/drug allergies: ______________________________

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