



Evansville Multi-Specialty Clinic, PC

812-475-1948 • Toll Free: 1-888-401-4DOC • Fax: 812-401-1267 • www.evansvilleclinic.com
6140 E Columbia St Evansville, IN 47715

Name: _____

Past Medical History: If you are offended by the personal nature of a question please do not answer

<p>General Health Issues:</p> <input type="checkbox"/> Weight Gain/Loss <input type="checkbox"/> Fatigue <input type="checkbox"/> Fever <input type="checkbox"/> Sleep Problems <p>Eyes:</p> <input type="checkbox"/> Blurred Vision <input type="checkbox"/> Visual Changes <input type="checkbox"/> Double vision <input type="checkbox"/> Corrective Lenses <input type="checkbox"/> Itchy Eyes <p>Ears/Nose/Mouth/Throat:</p> <input type="checkbox"/> Ear Pain <input type="checkbox"/> Difficulty in hearing <input type="checkbox"/> Sinus Problems <input type="checkbox"/> Runny Nose <input type="checkbox"/> Post Nasal drip <input type="checkbox"/> Mouth sore/Ulcer <input type="checkbox"/> Gum bleeding <input type="checkbox"/> Pain on swallowing <input type="checkbox"/> Hoarseness <p>Breasts:</p> <input type="checkbox"/> Pain <input type="checkbox"/> Lump/mass <input type="checkbox"/> Nipple discharge	<p>Respiratory :</p> <input type="checkbox"/> Difficultly Breathing <input type="checkbox"/> Wheezing <input type="checkbox"/> Cough <input type="checkbox"/> Regular Sputum production <input type="checkbox"/> Exercise induced cough/wheezing <input type="checkbox"/> Asthma <p>Cardiovascular:</p> <input type="checkbox"/> Shortness of breath <input type="checkbox"/> Chest pain/tightness <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart attack <input type="checkbox"/> Leg pain <input type="checkbox"/> Leg swelling <p>Integumentary/Skin:</p> <input type="checkbox"/> Skin color/texture <input type="checkbox"/> Itching <input type="checkbox"/> Rashes <input type="checkbox"/> Ulcers <input type="checkbox"/> Worrisome growths	<p>Gastrointestinal:</p> <input type="checkbox"/> Decreased appetite <input type="checkbox"/> Constipation <input type="checkbox"/> Bloating/belching <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Nausea/vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Change in bowels <input type="checkbox"/> Bloody stool <input type="checkbox"/> Black, tarry stools <input type="checkbox"/> Hemorrhoids <p>Urinary and Genital:</p> <input type="checkbox"/> Frequent urination <input type="checkbox"/> Pain on urination <input type="checkbox"/> Hesitancy <input type="checkbox"/> Incontinence <input type="checkbox"/> Awake at night to urinate <input type="checkbox"/> Problems with erection/impotence <input type="checkbox"/> Prostate problems <input type="checkbox"/> Decreased interest In sex <p>Musculoskeletal:</p> <input type="checkbox"/> Joint pain <input type="checkbox"/> Muscle/bone pain	<p>Neurological:</p> <input type="checkbox"/> Headaches <input type="checkbox"/> Dizziness <input type="checkbox"/> Numbness <input type="checkbox"/> Tremors <input type="checkbox"/> Seizures <input type="checkbox"/> Fainting <p>Psychiatric:</p> <input type="checkbox"/> Anxiety <input type="checkbox"/> Feel sad or down <input type="checkbox"/> Decreased interest in normal activities <input type="checkbox"/> Mood Swings <p>Endocrine:</p> <input type="checkbox"/> Thyroid problem <input type="checkbox"/> Frequent thirst <input type="checkbox"/> Excessive sweating <p>Hematologic/Lymphatic:</p> <input type="checkbox"/> Easy bruising <input type="checkbox"/> Bleeding tendency <input type="checkbox"/> Swollen Lymph nodes
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Past Medical History:

Please check if you suffer from, or have been treated for any of the following medical conditions:
 Hypertension () Diabetes () Heart Attack () Asthma () Stroke () HIV (AIDS) () Obesity
 Congestive Heart Failure () High Cholesterol () Arthritis () History of blood transfusions
 Cancer: What kind and when? _____

Have you been admitted to a hospital during the past five years? () Yes () No

If yes, reason for admission: _____

Past Surgical History:

Please list any surgeries you have had and the year:

Current Medications:

Please list any prescribed and over the counter medication you are currently taking:

Medication _____	Dosage _____	How Often: _____
Medication _____	Dosage _____	How Often: _____
Medication _____	Dosage _____	How Often: _____
Medication _____	Dosage _____	How Often: _____
Medication _____	Dosage _____	How Often: _____

Allergies:

Do you have any allergic or adverse reactions to any medications or substances? () Yes () No

If yes, please list (and your reaction):

Social History:

Smoke () Yes () No If yes, # of cigarettes/packs _____ per day/week (Quit date: _____)

Alcohol () Yes () No If yes, # of glasses per day/week _____

Do you use any illicit (street) drugs? () Yes () No If yes, please list _____

Do you exercise? () Yes () No If yes, how many times per week? _____

Please check the appropriate box: () Married () Single () Widowed () Divorced () Separated

Number of children: _____

Family History:

Please check if any of the following diseases run in you family, and if yes, indicate which relative(s):

Hypertension () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Diabetes () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Heart Disease () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Stroke () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Cancer () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Osteoporosis () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Glaucoma () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Mental Illness () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N
Drug/Alcohol Addiction () No () Yes (circle all that apply)	Mother	Father	Brother	Sister	Living? Y or N

Sexual History:

Are you sexual active? () Yes () No If yes, are you active with () men () women () both

For Women only:

Are you pregnant? () Yes () No Nursing? () Yes () No Births? _____ Miscarriages? _____

Are you taking birth control? () Yes () No Last Menstrual Period: _____ Age of Onset? _____

Frequency: _____ Length of Period: _____ Last Mammogram: _____

Prolonged or abnormal bleeding? () Yes () No

Last pap smear: _____ History of abnormal pap smears: () Yes () No

Screening:

Last physical exam: _____ Cholesterol Level: _____ Colonoscopy: _____

PSA testing: _____ Digital rectal exam: _____ Stool Cards: _____

X _____
Patient/Guardian Signature Date