

ROUTINE CANCER SCREENING TESTS: *List last date (if known)*

Mammogram: _____

Breast Exam: _____

Pap Smear/Pelvic Exam: _____

Stool for Occult Blood: _____

Prostate Exam/PSA: _____

Chest X-Ray: _____

Colonoscopy/Sigmoidoscopy: _____

SOCIAL HISTORY:

Marital Status: _____

Number of Children: _____ Age/Sex of Children: _____

Spouse Name: _____

Spouse Occupation: _____

Patient Occupation: _____

Highest Level of Education: _____

Patient Lives With:	Self	<input type="checkbox"/>	Child	<input type="checkbox"/>
	Spouse	<input type="checkbox"/>	Parent(s)	<input type="checkbox"/>
	Sibling(s)	<input type="checkbox"/>	Friend	<input type="checkbox"/>
			Other	<input type="checkbox"/> _____

City of Residence: _____ Have you completed an advance directive? Yes
 No

Have you completed a living will? Yes
 No

Smoking History

Cigarettes	<input type="checkbox"/>	How Many Years?	_____
Cigars	<input type="checkbox"/>	Number Per Day	_____
Pipe	<input type="checkbox"/>	If Quit, When?	_____

Alcohol History

Beer	<input type="checkbox"/>	How Many Years?	_____
Wine	<input type="checkbox"/>	How Much Per Day/Week/Month?	_____
Liquor	<input type="checkbox"/>	If Quit, When?	_____

Recreational Drug Use Blood Transfusions HIV Testing

Nutritional Supplements: _____

CONTINUE REVIEW OF SYSTEMS: *Please check all boxes that apply*

URINARY/GYN	BLOOD IN URINE <input type="checkbox"/>	# OF PREGNANCIES _____	
	BURNING WITH URINATION <input type="checkbox"/>	# OF MISCARRIAGES _____	SPOTTING <input type="checkbox"/>
	FREQUENT URINATION <input type="checkbox"/>	# OF ABORTIONS _____	CRAMPING <input type="checkbox"/>
	DIFFICULTY STARTING TO URINATE <input type="checkbox"/>	# OF CHILDREN _____	DISCHARGE <input type="checkbox"/>
	BLADDER/ KIDNEY INFECTIONS <input type="checkbox"/>	LAST MENSTRUAL PERIOD _____	VAGINAL INFECTIONS <input type="checkbox"/>
	GETTING UP AT NIGHT TO URINATE <input type="checkbox"/>	DURATION _____	LAST PAP SMEAR _____
	SENSE OF FULL BLADDER <input type="checkbox"/>	INTERVAL _____	
SKIN	RASH <input type="checkbox"/>	ITCHING <input type="checkbox"/>	CHANGE IN HAIR OR NAILS <input type="checkbox"/>
NEURO-MUSCULAR	JOINT STIFFNESS <input type="checkbox"/>	SWELLING <input type="checkbox"/>	NIGHT CRAMPS <input type="checkbox"/>
	JOINT PAIN <input type="checkbox"/>	BACK PAIN <input type="checkbox"/>	VARICOSE VEINS <input type="checkbox"/>
HEMATOLOGICAL	EASY BRUISING OR BLEEDING <input type="checkbox"/>	ANEMIA <input type="checkbox"/>	PAST INFUSION <input type="checkbox"/>
			TRANSFUSION REACTIONS <input type="checkbox"/>
ENDOCRINE	THYROID PROBLEMS <input type="checkbox"/>	HOT OR COLD INTOLERANCE <input type="checkbox"/>	EXCESSIVE THIRST OR HUNGER <input type="checkbox"/>
PSYCHIATRIC	ANXIETY <input type="checkbox"/>	DEPRESSION <input type="checkbox"/>	MEMORY LOSS <input type="checkbox"/>
	NERVOUSNESS <input type="checkbox"/>		

PATIENT'S SIGNATURE: _____

PHYSICIAN'S SIGNATURE: _____