FOGARTY SURGICAL SERVICES & FAMILY CARE CLINIC

BRIEF HISTORY

Last name:	First:	Sex:	DOB:

What are you being seen for today?

PAST MEDICAL HISTORY

Check (√) if you have ever had any of the following:

□ AIDS	□ Chicken Pox	□ HIV positive	□ Rheumatic fever
□ Abdominal bleeding	□ Diabetes	□ Kidney disease	□ Scarlet fever
□ Accidents	□ Diverticulosis	□ Kidney Stones	□ Shortness of breath
□ Alcoholism	□ Emphysema	□ Liver disease	□ STDs
□ Allergies/hayfever	□ Epilepsy	□ Lung problems	□ Stroke
□ Anemia	□ Gallstones	□ Measles	□ Thyroid problem
□ Arthritis	□ Glaucoma	□ Mental illness	□ Tonsilitis
□ Asthma	□ Gout	□ Migraine headaches	□ Tuberculosis
□ Bleeding problems	□ Hearing trouble	□ Mumps	□ Typhoid fever
□ Blood clots	□ Heart disease	□ Osteoporosis	□ Ulcers
□ Breast lump	□ Heart murmor	□ Pacemaker	□ Urinary tract infections
□ Broken bones	□ Heart trouble/attack	□ Peptic ulcers	□ Vaginal Infections
□ Bronchitis	□ Hemorrhoids	□ Pneumonia	□ Varicose veins
□ Cancer	□ Hepatitis	□ Polio	□ Venereal disease
□ Chest pain/tightness	□ Hernia	□ Prostate problems	□ Vision trouble
□ Cataracts	□ High blood pressure	□ Psychiatric Care	□ Yellow jaundice
□ Depression	□ High cholesterol	□ Rhematoid arthritis	

PAST SURGICAL HISTORY □ None

Year	Name of Operation	Location/Surgeon	Complications

FAMILY HISTORY

Relation	Age	Diseases/Illnesses/Cause of death	Has any blood relatives had:	√	Relationship to you
Father			Arthritis, Gout		
Mother			Asthma, Hay Fever		
Brothers			Cancer		
			Chemical Dependincy		
			Diabetes		
			Gallbladder Disease		
			Heart Disease, Strokes		
Sisters			High Blood Pressure		
			Kidney Disease		
			Tuberculosis		
			Varicose Veins		
			Other:		

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SOCIAL HISTORY

Marital Status:	Children:	Occupation:	
Do you now use tobacco?	□Yes □No	# per day ___ / Years:_____	Type:
Have you ever used tobacco?	□Yes □No	Yrs Quit_____	Type:
Do you drink alcohol?	□Yes □No	# per day ___ / Years:_____	Type:
Have you ever used alcohol?	□Yes □No	Yrs Quit_____	Type:

MEDICATIONS □ NONE

Please list ALL medications, vitamins, suppliments:

Medication	Dose / Frequency	Who prescribed?

ALLERGIES □ None

REVIEW OF SYSTEMS

Check (√) symptoms you currently have or have had in the past year.

GENERAL

□ Chills
□ Depression
□ Dizziness
□ Fainting
□ Fever
□ Fatigue
□ Forgetfulness
□ Headache
□ Loss of Sleep
□ Loss of Weight
□ Nervousness
□ Numbness
□ Sweats

MUSCLE/JOINT/BONE

Pain, weakness, numbness in:

□ Arms □ Hips
□ Back □ Legs
□ Feet □ Neck
□ Hands □ Shoulders

GENITO-URINARY

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

GASTROINTESTINAL

□ Appetitie poor
□ Bloating
□ Bowel changes
□ Constipation
□ Diarrhea
□ Excessive hunger
□ Excessive thirst
□ Gas
□ Hemorrhoids
□ Indigestion
□ Nausea
□ Rectal bleeding
□ Stomach pain
□ Vomiting
□ Vomiting blood

CARDIOVASCULAR

□ Chest pain
□ High blood pressure
□ Irregular heart beat
□ Low blood pressure
□ Poor circulation
□ Rapid hearth beat
□ Swelling of ankles
□ Varicose veins

EYE, EAR, NOSE, THROAT

□ Bleeding gums
□ Blurred vision
□ Difficulty swallowing
□ Double vision
□ Earache
□ Ear discharge
□ 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
□ Sore on Penis
□ Other:

WOMEN only

□ Abnormal Pap Smear
□ Bleeding between periods
□ Breast lump
□ Extreme menstrual pain
□ Hot flashes
□ Nipple discharge
□ Painful intercourse
□ Vaginal discharge
□ Other:

Date of last period:
Date of last Pap:
Have you had a mammogram?
When:
Where:
Are you pregnant?

To the best of my knowledge, the above information is true and accurate.

Patient Signature: Date: