Bay Area Oriental Family Practice, PA.

Last Name	First Name	Middle Name	AGE	SEX M F	Exam Date

What is your Major Medical Complaint? When did the problem first begin?

YES	NO	Have you ever had?	Have you ever had?	No	Mild	Often	Have you ever had?	No	Mild	Often
		Scarlet Fever	CARDIOVASCULAR				GENITOURINARY			
		Diphtheria	Chest Pain/Pressure				Urgent Urination			
		Rheumatic Fever	Ankle Swelling				Frequent Urination			
		Frequent Colds	High Blood Pressure				Painful Urination			
		Sinusitis	Rapid Heart Beat				Burning Urination			
		Tuberculosis	Irregular Heart Beat				Pain in Testicles			
		Stomach, Liver, Intestinal Problems	Shortness of Breath w/ Normal Activity				Bloody or Other Discharges			
		Heart Murmur	Dizziness				Loss of Sexual Ability or Desire			
		Heart Attack	Fainting Spells				MUSCULO-SKELETAL			
		Other Heart Cond.	RESPIRATORY				Arthritis			
		Gall Bladder, Stones	Cough				Painful Joints			
		Jaundice	Cough w/Blood				Lameness			
		Adverse Reaction to Medicine or Serum	Hoarseness				Muscle Pain or Cramping			
		Tumor, Cyst, Cancer	Sore Throat				Backaches			
		Piles, Rectal Disease	Sneezing				Weakness			
		Kidney Stones	Hay Fever				MISCELLANEOUS			
		Sugar, Albumin or Blood in Urine	Nose Bleeds				Fever			
		Venereal Disease	Chest /Rib Pain				Chills			
		Drug, Narcotics Habit	Asthmatic Wheezing				Night Sweats			
	/day	No. Of Alcohol Drinks per Day	Pneumonia				Headaches			
		Wear Glasses	GASTROINTESTINAL				Insomnia			
		Eye Problems	Indigestion				Nervousness			
		Ear, Nose, or Throat Problems	Abdominal Pain/Cramps				Irritability			
YES	NO	WOMEN ONLY	Constipation				Morning Tiredness			
		Pregnant # of Time___ # Of Live Birth_____	Diarrhea				Easy Fatigability			
		Vaginal Discharge	Blood in Stools				CHECK EACH ITEM		YES	NO
		Treated for Female Disorder	Black Stools				Have you ever been rejected for or discharged from military service because of physical, mental or other reasons?			
		Painful Menstruation	Increased Appetite							
		Irregular Menses	Increased Thirst							
	/years Old	Age at onset of Menstruation	Decreased appetite				Have you ever been denied life insurance?			
		Interval between Periods	Nausea & Vomiting				Have you ever been refused employment because of your health?			
		Duration of Periods	Difficulty Swallowing							
		Date of Last Period	Food Preference (Circle One) Sweet Sour Spicy Salty Bitter Pungent							
		Normal	SKIN				Do you or have you ever smoked?			
		Excessive	Ulcerations							
		Scanty	Itching				#Per day? _____ # Of Years_____			
			Rashes				Date of Last Cigarette_____			

(See reverse side)

Do you have or have you had recently?	Yes	No	For How Long?	Please List prescriptions, medications, and supplements you currently take:	For what condition do you take it? How long have you been taking it?
Weight Loss: How Much( )					
Weight Gain: How Much( )					
Memory defect					
Change in Handwriting					
Difficulty walking in the dark					
Balance Problems					
Hearing Loss					
Ringing in the ears					
Vision Changes					
Double Vision					
Earaches					
Ear Discharge			Color?_____		
New Skin Growths					
Change in Skin Color					
Tendency to Bleed or Bruise easily				Please note any hospitalizations or significant conditions for which you received treatment in the past year:	Please note the problem that led to the hospitalization or treatment:
Athlete's Foot					
Intolerant of heat					
Intolerant of Cold					
Intolerant of wind/breeze					
Change in shoe or hat size					
Lymph node enlargement					
Prefer hot drinks/food					
Prefer cold drinks/food					
Is there any other physical fitness or health issue you would like to bring to the attention of the examiner today?				Are there any other factors in your physical condition not already covered that you have questions about?	If so, What?
(If yes, please explain)					

Is there a family history of the following?	Yes	No	Relationship? (ex. Father)	Please List all operations you have undergone:	Please list your approximate age when each was performed:
Tuberculosis					
Diabetes					
Cancer					
Gout					
Heart trouble					
Strokes					
High blood Pressure					
Asthma, hay fever, hives					
Glaucoma					