CMB Health Specialties

Name:_____ Date of Birth: _____ Today's Date: _____

Occupation: _____ All Previous Occupations: _____

Birth Place: _____ List states in which you lived: _____

Education: _____ years in High School _____ years in College _____ years Post Grad.

Date of last physical examination: _____
□Routing Check-up – No Symptoms OR
Please list all symptoms concerning your visit.

1. _____
2. _____
3. _____
4. _____
5. _____

Note: This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

	If Living Age	If Living Health	If Deceased Age at Death
Father			
Mother			
Brother or Sister	1.		
	2.		
	3.		
	4.		
	5.		
Husband or Wife			
Son or Daughter	1.		
	2.		
	3.		
	4.		
	5.		

Has any blood relative ever had	Please Circle	
Cancer	Yes	No
Name Types:_____		
Tuberculosis	Yes	No
Diabetes	Yes	No
Heart Trouble	Yes	No
High Blood Pressure	Yes	No
Stroke	Yes	No
Epilepsy	Yes	No
Insanity	Yes	No
Suicide	Yes	No
Thyroid Problems	Yes	No

Personal History

Illnesses: Have you ever had
(Please circle all answers)

Measles	Yes	No
German Measles	Yes	No
Mumps	Yes	No
Chicken Pox	Yes	No
Whooping Cough	Yes	No
Scarlet Fever or Scarlatina	Yes	No
Diphtheria	Yes	No
Smallpox	Yes	No
Pneumonia	Yes	No
Influenza	Yes	No
Pleurisy	Yes	No
Rheumatic Fever or Heart Dz.	Yes	No
Arthritis or Rheumatism	Yes	No
Neuritis or Neuralgia	Yes	No
Bursitis, Sciatica or Lumbago	Yes	No
Polio or Meningitis	Yes	No
Nephritis	Yes	No
Gonorrhea or Syphilis	Yes	No
Gallbladder Disease	Yes	No
Anemia	Yes	No
Jaundice	Yes	No
Bladder Disease	Yes	No
Epilepsy	Yes	No
Migraine headaches	Yes	No
Tuberculosis	Yes	No
Diabetes	Yes	No
Cancer	Yes	No
High or low blood pressure	Yes	No
Colitis or other bowel disease	Yes	No
Hemorrhoid/disease	Yes	No
Nervous Breakdown	Yes	No
Food, chemical or drug poisoning	Yes	No
Hay fever or Asthma	Yes	No
Hives or Eczema	Yes	No
Frequent infections or boils	Yes	No
AIDS	Yes	No
Any other disease	Yes	No

_____

ALLERGIES: Are you allergic to

Penicillin or Sulfa	Yes	No
Aspirin, Codeine or Morphine	Yes	No
Mycins or other Antibiotics	Yes	No
Merthiolate or Mercurochrome	Yes	No
Any other drug	Yes	No
Any foods	Yes	No
Adhesive Tape	Yes	No
Nail Polish or other cosmetics	Yes	No
Tetanus Antitoxin or Serums	Yes	No

INJURIES: Have you had any:

Broken or cracked bones	Yes	No
Sprains	Yes	No
Lacerations	Yes	No
Dislocations	Yes	No
Concussion, or head injury	Yes	No
Ever been knocked unconscious	Yes	No

WEIGHT: Now ____ 1 yr ago _____
Max. _____ When: _____

TRANSFUSIONS: Ever had
Blood or Plasma Transfusions Yes No

SURGERY: Ever had

Tonsillectomy	Yes	No
Appendectomy	Yes	No
Gallbladder	Yes	No
Joint	Yes	No
Back	Yes	No

Any other operation
Type: _____ Year: _____
Type: _____ Year: _____
Type: _____ Year: _____
Have you ever been advised to have any Surgical operation, which has not been done? Yes No

Have you been hospitalized?
For illness Yes No
Give details:_____
_____
_____
_____

Did you ever smoke? Use tobacco? Yes No
Do you smoke presently? Yes No
How many per day? _____
Do you use recreational drugs? Yes No
Do you use alcohol regularly? Yes No
Do you use caffeine/power drinks? Yes No

Symptoms Past and Present:

Frequent or severe headaches	Yes	No
Fainting Spells	Yes	No
Dizziness on change of position	Yes	No
Unconscious spells	Yes	No
Blurred Vision	Yes	No
Double Vision	Yes	No
Spots before eyes	Yes	No
Infected eyes	Yes	No
Pain behind eyes	Yes	No
Any change in vision	Yes	No
Do you wear glasses	Yes	No
When were you checked last? _____		
Earaches	Yes	No
Discharged from ears	Yes	No
Ringing or buzzing in ears	Yes	No
Difficulty hearing	Yes	No
Recurrent nose bleeds	Yes	No
Sinus Trouble/Sneezing spells	Yes	No
Hay fever / Stuffy nose	Yes	No
Sore tongue	Yes	No
Strange taste or loss in taste	Yes	No
Persistent hoarseness	Yes	No
Difficulty swallowing	Yes	No
Recurrent sore throats	Yes	No
Canker sores	Yes	No
Soreness or bleeding of gums on brushing	Yes	No
Problems with teeth	Yes	No
Chest Pain	Yes	No
Racing heart	Yes	No
Coughed up blood	Yes	No
Racing heart	Yes	No
Night sweats	Yes	No
Chronic or frequent cough	Yes	No
Chronic or frequent cough on laying down	Yes	No
Wake up at night short of breath	Yes	No
How many bed pillows do you use? _____		
Shortness of breath on:		
Walking several blocks	Yes	No
One flight of stairs	Yes	No
On laying down	Yes	No
Purple lips or fingers	Yes	No
Low blood pressure	Yes	No
High blood pressure	Yes	No
Swelling of hands, feet or ankles	Yes	No
At what time of day? _____		
Leg cramps on walking or at night	Yes	No
Enlarged veins in legs	Yes	No
Recurrent stomach pain	Yes	No
Belching / heartburn/ bloating after eating	Yes	No
Relieved by food or medication	Yes	No
Appetite: ___ Good ___ Fair ___ Poor		
Nausea or vomiting	Yes	No
Vomited blood	Yes	No
Avoid some foods	Yes	No
What kinds: _____		
Abdominal cramping	Yes	No
Diarrhea/Constipation	Yes	No
Any blood in BM	Yes	No
Rectal pain with bowel movement	Yes	No
Pain during urination	Yes	No
Difficulty in starting/stoping urination	Yes	No
Do you get up at night to urinate	Yes	No
How many times? _____		
Blood in urine	Yes	No
Lose urine on coughing or sneezing	Yes	No
Discharge from penis	Yes	No
Recurrent back pain	Yes	No
Joint pain/swelling?	Yes	No
Which?_____		
Joint redness	Yes	No
Muscle spasms	Yes	No
Tingling or weakness of hands or feet	Yes	No
Loss or change in sensation of hands or feet	Yes	No
Trembling of any extremity	Yes	No
Change in handwriting	Yes	No
Growth in neck or throat	Yes	No

Hot flashes	Yes	No
Tiredness without apparent reason	Yes	No
Brittleness of nails	Yes	No
Dryness of skin	Yes	No
Easy bruising	Yes	No
Inability to stand heat/cold	Yes	No
Change in skin or hair texture	Yes	No
Skin rash	Yes	No

Imaging:

Recent X-rayof_____

Recent MRI of _____

Recent CT of _____

Recent dental scan	Yes	No
Other_____	Yes	No

Date of last EKG_____

Immunizations: Have you had? (Circle)

Childhood Immunizations Gardasil Shingles Flu Shots

Pneumonia Others:_____

DRUGS:	**Never**	**Occ.**	**Freq**	**Daily**	**In Past**
Laxatives	_____	_____	_____	_____	_____
Vitamins	_____	_____	_____	_____	_____
Sedatives	_____	_____	_____	_____	_____
Pain Pills	_____	_____	_____	_____	_____
Tranquilizers	_____	_____	_____	_____	_____
Sleeping Pills, etc	_____	_____	_____	_____	_____
Aspirins	_____	_____	_____	_____	_____
Cortisone, ACTH	_____	_____	_____	_____	_____
Thyroid	_____	_____	_____	_____	_____
Appetite depressants	_____	_____	_____	_____	_____

Have you ever been treated for drug dependency	Yes	No
Have you ever taken insulin or tablets for diabetes	Yes	No
Have you ever taken hormones	Yes	No

Men Only

Prostate Trouble	Yes	No
ED	Yes	No

Women Only – Menstrual History

Age at onset _____

Regular? _____ Yes _____ No _____ Varies

Cycle: _____days (from start to finish)

Flow: _____ Heavy _____ Medium _____ Light

Pains or cramps	Yes	No

Date of last period? _____

Date of last pelvic exam? _____

Date of last Pap test? _____

Results:_____ Negative _____ Positive

Any discharge from vagina	Yes	No

If so, color _____

Amount: _____

Any itching of vaginal area	Yes	No
Do you take birth control pills?	Yes	No

How long have you taken them? _____

Date of last mammogram_____

Pregnancies:

How many pregnancies? _____

How many children?_____

Any complications with pregnancy?	Yes	No

Describe: _____

Other important information about your health:_____

_____

_____

_____