NORTHSIDE HOSPITAL
DIAGNOSTIC CLINIC

Full Name: ______________________ Date: ______________

Birth Date: ______________________ Age: ______________

FAMILY HISTORY: Please include age at death

	Father	Mother	Grandparents	Siblings
Alzheimer's Disease				
Asthma				
Bleeding Disorder				
Cancer				
Diabetes				
Heart Disease				
High Blood Pressure				
Kidney Disease				
Migraines				
Stroke				
Thyroid Disease				
Other:				

ALLERGIES:

Medication/Food/Other that causes allergy	Type of reaction (hives, swelling, etc.)?

CURRENT MEDICATIONS: Please list all current medications you are taking, including but not limited to: blood pressure medicine, heart medicine, diuretic (water) pill, diabetes medicine, thyroid medicine, pain medicine, nerve pill/antidepressants, asthma medicine, hormones, herbal supplements, vitamins, etc.

HEALTH SCREENING:

Last Mammogram: ______________ Last Bone Density: ______________

Last Pap Smear: ______________ Last Colonoscopy: ______________

Diabetic Eye Exam: ______________

Name: ______________________________________ Date of Birth: __________________

PAST MEDICAL HISTORY: Check any problem you have been diagnosed with or received treatment for:

o Acid Reflux
o ADD/ADHD
o Allergies
o Anemia/Low Blood Counts
o Anxiety
o Arthritis
o Asthma
o Bipolar Disorder/ Manic-Depressive Disorder
o Bleeding Disorder
o Blood clot in legs/lungs
o Cancer
o Congestive Heart Failure
o COPD

o Depression
o Diabetes
o Glaucoma/Cataracts
o Gout
o Heart Attack
o Hepatitis
o High Blood Pressure
o High Cholesterol/Triglyceride
o HIV
o Kidney Disease/Stones
o Lupus

o Osteoporosis
o Pancreatitis Inflamed Pancreas
o Pneumonia
o Prostate Problems
o Rheumatic Fever
o Sexually Transmitted Disease
o Skin Problems
o Stomach Ulcer
o Stroke
o Treated for Irregular Heartburn
o Treated with blood thinner
o Tuberculosis

Other Conditions:

____

____

PAST SURGICAL PROCEDURES: (please list all and year)

SOCIAL HISTORY:

o Current Smoker: ____packs//day for ____# of years
o Previous Smoker: Quit date: _______
o Smokeless Tobacco
o Pipe
o Cigars
o Vaping

o Married o Divorced o Single o Widowed
o Do you drink alcohol? o No o Yes
If yes, how many drinks per day? ___________
o Use Illegal/Recreational Drugs: o Past o Present
o Exercise habits__________
o Exercise x/week _________

CHILDREN

Age	Male/Female	City/State

Occupation (if retired, what was your occupation): ____

IMMUNIZATIONS: (please fill in date last administered)

Tetanus		Pneumonia shot (type)	
Flu vaccine		Shingles vaccine	
Hepatitis B (set of 3)		Any others:	

Name: ______________________________ DOB: ______________________

To be answered by WOMEN only

Please circle Yes or No and explain yes answers.

Abnormal vaginal bleeding	YES	NO	______
Abnormal vaginal discharge	YES	NO	______
Vaginal dryness	YES	NO	______
Vaginal itching	YES	NO	______
Pain with having sex	YES	NO	______
Breast lump	YES	NO	______
Breast pain	YES	NO	______
Nipple discharge	YES	NO	______

To be answered by MEN only

Please circle Yes or No and explain yes answers.

Are you concerned about your sexual function?	YES	NO	______
If yes, do you have trouble getting/maintaining an erection?	YES	NO	______
Discharge from penis	YES	NO	______
Have you ever been treated for difficultly getting an erection?	YES	NO	______
Have you ever been treated for low testosterone?	YES	NO	______
Hernia (rupture)?	YES	NO	______
Prostate trouble?	YES	NO	______

Write in the names of any diseases you have had which required hospitalization:

____

____

Serious Illnesses which you have had: (not requiring hospitalization)

____

____

Serious injuries or accidents:

____

____

Name: ______________________________ DOB: ______________________

REVIEW OF SYSTEMS (Please verify if you have had any of the following <u>within the last 30 days)</u>

Please circle Yes or No and explain yes answers.

GENERAL

Fatigue, tiredness YES NO ____________
Increased thirst or urination YES NO ____________
Fever or chills YES NO ____________
Any new lumps/bumps on the body YES NO ____________
Unexplained weight loss YES NO ____________
Unexplained weight gain YES NO ____________
Night sweats YES NO ____________
Difficulty with sleep YES NO ____________

EYES

Changed vision YES NO ____________
Red eye(s) YES NO ____________
Dry eye(s) YES NO ____________
Painful eye(s) YES NO ____________
Spots/wavy lines YES NO ____________
Flashes with eye movement YES NO ____________
Flickering lights YES NO ____________
Do you wear contacts YES NO ____________

EARS, NOSE, AND THROAT

Bleeding from the nose YES NO ____________
Snoring YES NO ____________
Recurring sinus infections YES NO ____________
Bothersome nasal allergies YES NO ____________
Trouble breathing through your nose YES NO ____________
Problems with taste or smell YES NO ____________
Ringing in the ears YES NO ____________

PSYCHIATRIC

Anxiety YES NO ____________
Depression YES NO ____________
Thoughts of hurting yourself YES NO ____________
Thoughts of hurting others YES NO ____________

MUSCULOSKELETAL

Neck pain YES NO ____________
Back pain YES NO ____________
Joint pain YES NO ____________
Redness of swelling of any joints YES NO ____________

URINARY

Pain with urination YES NO ____________
Blood in urine YES NO ____________
Urinating too frequently YES NO ____________
Trouble with ease of urinary flow YES NO ____________

SKIN

New moles YES NO ____________
New rash YES NO ____________
Psoriasis YES NO ____________
Persistent itching YES NO ____________
Sores/open wounds YES NO ____________

CV

Chest Pain YES NO ____________
Episode of rapid or irregular heartbeat YES NO ____________
Swelling in legs/feet YES NO ____________
Awakening at night because of shortness of breath YES NO ____________

RESPIRATORY

Shortness of breath YES NO ____________
Wheezing YES NO ____________
Cough YES NO ____________
Coughing up blood YES NO ____________
Have you been told you stop breathing in your sleep YES NO ____________

GI

Abdominal pain YES NO ____________
Difficulty with swallowing YES NO ____________
Pain with swallowing YES NO ____________
Black stool YES NO ____________
Blood in your stool YES NO ____________
Constipation YES NO ____________
Diarrhea YES NO ____________
Vomiting YES NO ____________
Nausea YES NO ____________
Heartburn/Acid Reflux YES NO ____________

NEUROLOGIC

Headaches YES NO ____________
Fainting spells YES NO ____________
Episodes of seizures YES NO ____________
Vertigo/Room spinning YES NO ____________
Frequent falling YES NO ____________

HEMATOLOGIC

Abnormal bruising YES NO ____________
Abnormal bleeding YES NO ____________
Recurrent blood clots YES NO ____________

Patient's Signature: ______________________________ **Date:** ______________

Date: ____________________________

Name: _________________________

DOB: _____________________________

Emergency Contact name: _______________________

Phone Number: ____________________

Pharmacy Name and Location: ____

OTHER PROVIDERS /SPECIALISTS:

Doctor Name	Specialty	Phone number