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Name _____ Chart # _____

REASON FOR VISIT

FAMILY HISTORY *If any blood relative has suffered any of the following, please circle the number & indicate which relative.*

- | | | | |
|------------------|---------------------|---------------------|------------------------|
| Epilepsy _____ | Thyroid _____ | Osteoporosis _____ | High Cholesterol _____ |
| Migraine _____ | Hayfever _____ | Arthritis _____ | Alcoholism _____ |
| Mental Ill _____ | Asthma _____ | Heart Disease _____ | Cancer _____ |
| Glaucoma _____ | Anemia _____ | Stroke _____ | Other _____ |
| Diabetes _____ | Bleeds Easily _____ | Hypertension _____ | Other _____ |

HOSPITAL ADMISSIONS	YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION
NOT INCLUDING PREGNANCIES	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____

LIST ALL MEDICATIONS YOU ARE NOW TAKING (Include those without a prescription)	ALLERGIES (Include drug allergies)	VACCINE	YR. OF LAST	TEST/EXAM	YR. OF LAST
1. _____ 7. _____	_____	Tetanus/Td _____	_____	Rectal/Stool _____	_____
2. _____ 8. _____	_____	Influenza (FLU) _____	_____	Cholesterol _____	_____
3. _____ 9. _____	_____	Pneumonia _____	_____	Eye _____	_____
4. _____ 10. _____	_____	Hepatitis _____	_____		
5. _____ 11. _____	_____	Tuberculosis _____	_____		
6. _____ 12. _____	_____				

MEDICAL HISTORY *Mark (C) for current problems. Check (✓) and indicate age when you had any of the following symptoms or diseases.*

- | | | | |
|---|---|---|--|
| <input type="checkbox"/> _____ Decreased hearing | <input type="checkbox"/> _____ Persistent nausea/vomiting | <input type="checkbox"/> _____ Muscle weakness | Coffee/tea ___ cups/day |
| <input type="checkbox"/> _____ Ringing in ear | <input type="checkbox"/> _____ Abdominal pain-chronic | <input type="checkbox"/> _____ Fever/chills | Alcohol ___ oz. per week |
| <input type="checkbox"/> _____ Ear infections-frequent | <input type="checkbox"/> _____ Gall bladder trouble | <input type="checkbox"/> _____ Numbness/Tingling | Year quit _____ |
| <input type="checkbox"/> _____ Dizzy spells | <input type="checkbox"/> _____ Jaundice/Hepatitis | <input type="checkbox"/> _____ Headaches-frequent | Tobacco ___ pks. per day |
| <input type="checkbox"/> _____ Fainting spells | <input type="checkbox"/> _____ Change in bowel habits | <input type="checkbox"/> _____ Arthritis/Rheumatism | Year quit _____ |
| <input type="checkbox"/> _____ Failing vision | <input type="checkbox"/> _____ Diarrhea | <input type="checkbox"/> _____ Back pain-recurrent | <input type="checkbox"/> _____ Regular exercise |
| <input type="checkbox"/> _____ Eye pain | <input type="checkbox"/> _____ Constipation | <input type="checkbox"/> _____ Bone fracture/Joint injury | MALES |
| <input type="checkbox"/> _____ Double or blurred vision | <input type="checkbox"/> _____ Diverticulosis | <input type="checkbox"/> _____ Gout | <input type="checkbox"/> _____ Prostate |
| <input type="checkbox"/> _____ Eye infections-frequent | <input type="checkbox"/> _____ Crohn's/Colitis | <input type="checkbox"/> _____ Osteoporosis | <input type="checkbox"/> _____ PSA test |
| <input type="checkbox"/> _____ Nose bleeds-recurrent | <input type="checkbox"/> _____ Bloody or tarry stools | <input type="checkbox"/> _____ Foot pain | FEMALES |
| <input type="checkbox"/> _____ Sinus trouble | <input type="checkbox"/> _____ Hemorrhoids | <input type="checkbox"/> _____ Cold numb feet | Menstrual Flow: |
| <input type="checkbox"/> _____ Sore throats-frequent | <input type="checkbox"/> _____ Hernia | <input type="checkbox"/> _____ Rashes | <input type="checkbox"/> _____ Reg |
| <input type="checkbox"/> _____ Hayfever/Allergies | <input type="checkbox"/> _____ Blood in urine | <input type="checkbox"/> _____ Hives | <input type="checkbox"/> _____ Irreg |
| <input type="checkbox"/> _____ Hoarseness-prolonged | <input type="checkbox"/> _____ Kidney stones | <input type="checkbox"/> _____ Psoriasis | <input type="checkbox"/> _____ Pain/cramps |
| <input type="checkbox"/> _____ Pneumonia/Pleurisy | Urination | <input type="checkbox"/> _____ Eczema | Days of flow _____ |
| <input type="checkbox"/> _____ Bronchitis/chronic cough | <input type="checkbox"/> _____ Overnight > than twice | <input type="checkbox"/> _____ Sleeping-difficulty | Length of cycle _____ |
| <input type="checkbox"/> _____ Asthma/wheezing | <input type="checkbox"/> _____ Painful | <input type="checkbox"/> _____ Depression | 1st day of last period _____ |
| Shortness of breath | <input type="checkbox"/> _____ Loss of control | <input type="checkbox"/> _____ Nervousness | <input type="checkbox"/> _____ Pain During/after sex |
| <input type="checkbox"/> _____ on exertion | <input type="checkbox"/> _____ Decrease in force/flow | <input type="checkbox"/> _____ Memory loss | <input type="checkbox"/> _____ bleeding During/after sex |
| <input type="checkbox"/> _____ on lying flat | <input type="checkbox"/> _____ Urethral discharge | <input type="checkbox"/> _____ Moodiness-excessive | Number of: _____ |
| <input type="checkbox"/> _____ Chest pain | <input type="checkbox"/> _____ Urine infections-frequent | <input type="checkbox"/> _____ Mental illness | Pregnancies _____ |
| <input type="checkbox"/> _____ High blood pressure | <input type="checkbox"/> _____ Venereal disease | <input type="checkbox"/> _____ Phobias | Abortions _____ |
| <input type="checkbox"/> _____ Heart murmur | <input type="checkbox"/> _____ Fatigue | <input type="checkbox"/> _____ Rheumatic fever | Miscarriages _____ |
| <input type="checkbox"/> _____ Swollen ankles | <input type="checkbox"/> _____ Weight loss-recent | <input type="checkbox"/> _____ Scarlet fever | Live births _____ |
| <input type="checkbox"/> _____ Irregular pulse | <input type="checkbox"/> _____ Anemia | <input type="checkbox"/> _____ Chicken pox | Birth control method _____ |
| <input type="checkbox"/> _____ Palpitations | <input type="checkbox"/> _____ Bruise easily | <input type="checkbox"/> _____ Polio | B.C. pill (name) _____ |
| <input type="checkbox"/> _____ Leg pain when walking | <input type="checkbox"/> _____ Cancer | <input type="checkbox"/> _____ Mumps | <input type="checkbox"/> _____ Flushing/Menopause |
| <input type="checkbox"/> _____ Varicose veins/Phlebitis | <input type="checkbox"/> _____ Diabetes | <input type="checkbox"/> _____ Measles | Date of last PAP test _____ |
| <input type="checkbox"/> _____ Loss of appetite | <input type="checkbox"/> _____ Thyroid disease | <input type="checkbox"/> _____ German measles | <input type="checkbox"/> _____ Normal |
| <input type="checkbox"/> _____ Difficulty swallowing | <input type="checkbox"/> _____ Seizures | <input type="checkbox"/> _____ Tuberculosis | <input type="checkbox"/> _____ Abnormal |
| <input type="checkbox"/> _____ Heartburn | <input type="checkbox"/> _____ Stroke | <input type="checkbox"/> _____ Herpes | Date of last mammogram _____ |
| <input type="checkbox"/> _____ Peptic ulcer | <input type="checkbox"/> _____ Tremors/hands shaking | | <input type="checkbox"/> _____ Normal |
| | | | <input type="checkbox"/> _____ Abnormal |

NOTES Whom may we thank for this referral? _____

Signature _____ M.D.