BROOKS-SMITH LOWE INSTITUTE

Name _____ Date of Birth _____ Age _____.

Address _____ Phone (H) _____ (W) _____ (C) _____.

Occupation _____ Email: _____ DATE

FAMILY HISTORY

IF ANY BLOOD RELATIVE HAS SUFFERED ANY OF THE FOLLOWING - PLEASE CIRCLE THE NUMBER AND INDICATE RELATIVE

1) EPILEPSY
2) MIGRAINE
3) MENTAL ILL.
4) GLAUCOMA
5) DIABETES
6) THYROID
7) HAYFEVER
8) ASTHMA
9) ANEMIA
10) ARTHRITIS
11) OSTEOPOROSIS
12) BLEEDS EASILY
13) HEART DISEASE
14) STROKE
15) HYPERTENSION
16) ALCOHOLISM
17) CANCER
18) HIGH CHOLESTEROL
19) OBESITY
20)

_____
_____
_____
_____

HOSPITAL ADMISSIONS

not including pregnancies

YEAR	ILLNESS OR OPERATION	YEAR	ILLNESS OR OPERATION

LIST ALL MEDICATIONS YOU ARE NOW TAKING

ALLERGIES	VACCINE Your last year	TEST/EXAM Your last year
	Tetanus	Rectal/stool
	Chickenpox	Cholesterol
	Hepatitis	Eye
	Influenza	Dental

MEDICAL HISTORY

MARK (C) FOR CURRENT PROBLEMS. CHECK ✓ AND INDICATE AGE WHEN YOU HAD ANY OF THE FOLLOWING SYMPTOMS OR DISEASES

MAIN PROBLEMS 1) 2) 3)

☐ Migraines
☐ Decreased Hearing
☐ Ringing in ear
☐ Ear infections – frequent
☐ Dizzy spells ☐ Fainting spells
☐ Failing vision ☐ Eye pain
☐ Double or blurred vision
☐ Eye infections – frequent
☐ Nose bleeds – recurrent
☐ Sinus trouble
☐ Sore throats – frequent
☐ Hayfever / Allergies
☐ Hoarseness – prolonged
☐ Pneumonia / Pleurisy
☐ Bronchitis / Chronic cough
☐ Asthma / Wheezing
☐ Shortness of breath:
☐ Chest pain
☐ High blood pressure
☐ Heart murmur ☐ Palpitations
☐ Irregular pulse ☐ Swollen ankles
☐ Leg pain – when walking
☐ Varicose veins / Phlebitis

DO NOT WRITE BELOW THIS LINE

☐ Loss of appetite – recent
☐ Difficulty swallowing
☐ Heartburn ☐ Peptic ulcer
☐ Persistent nausea / vomiting
☐ Abdominal pain – chronic
☐ Gall bladder trouble
☐ Jaundice / Hepatitis
☐ Change in bowel habits
☐ Diarrhea ☐ Constipation
☐ Diverticulosis ☐ Crohn's/Colitis
☐ Bloody and tarry stools
☐ Hemorrhoids ☐ Hernia
☐ Urine infections – frequent
☐ Blood in urine ☐ Kidney stones
Urination - ☐ overnight > than twice
☐ Painful ☐ Loss of control
☐ Decrease in force / flow
☐ Venereal disease
☐ Urethral discharge
☐ Chronic fatigue
☐ Weight loss ☐ Gain – recent
☐ Anemia ☐ Bruise easily
☐ Cancer

☐ Diabetes ☐ Thyroid disease
☐ Seizures ☐ Stroke
☐ Tremor / hands shaking
☐ Muscle weakness
☐ Numbness / tingling sensations
☐ Headaches – frequent
☐ Arthritis / Rheumatism
☐ Back pain – recurrent
☐ Bone fracture / joint injury
☐ Gout ☐ Osteoporosis
☐ Foot pain ☐ Cold numb feet
☐ Rashes ☐ Hives
☐ Psoriasis ☐ Eczema
☐ Sleeping or concentration diff.
☐ Depression ☐ Nervousness
☐ Agitation ☐ Memory loss
☐ Moodiness ☐ Suicidal thoughts
☐ Phobias ☐ Mental illness
☐ Feelings of worthlessness
☐ Rheumatic fever ☐ Polio
☐ Scarlet fever ☐ Chicken pox
☐ Mumps ☐ German Measles
☐ Tuberculosis ☐ Herpes
☐ HIV

☐ Alcohol _____oz per week
☐ Smoking _____cig/day_____#yrs
yr. Quit _____
☐ Coffee / tea _____ cups per day
☐ Recent hair loss

MALES – ☐ RECTAL EXAM
Date of last exam_____

FEMALES –please complete
Menstrual flow:
☐ Reg. ☐ Irreg. ☐ pain / cramps
Days of flow ____ Length of cycle ___
Date – 1st day of last period _____
☐ Pain/bleeding during or after sex
Number of:
Pregnancies _____ Abortions _____
Miscarriages ____ Live Births _____
Birth control method _____
B.C. pill (name) _____
☐ Flushing/Menopause
Date of last PAP test _____
☐ Normal ☐ Abnormal
Date of last Mammogram _____
☐ Normal ☐ Abnormal

SYNOPSIS