Family History:

For the following relatives, please describe the following: 1. Whether they are living or deceased, 2. What major health problems they have or have had, and, 3. If deceased, what was the cause of and age at death.

Mother: _____
Father: _____
Brother and/or Sisters: _____
Sons and/or Daughters: _____
Maternal Grandparents: _____
Paternal Grandparents: _____

Please list any Serious or Chronic illness you presently have or have had in the past (include any problem that required more than a short course of medication)

Please list any Surgeries and the approximate year they occurred:

Please list any Hospitalizations and explain the reason for them and approximate year:

Please list ANY Allergies, including medications, and what reactions occur or write "No Medical Allergies" if applicable:

Please answer the following questions as best as you can:

1. Has good luck or God/Providence played a role in your success in life?	Yes	No
2. Do you often see yourself as superior to others and deserving of special treatment?	Yes	No
3. Are you often perceived as arrogant and/or insensitive to others needs or emotions?	Yes	No
4. Do you have trouble with lying to or tricking others for pleasure or gain?	Yes	No
5. Do you feel sorry for people who have been tricked or conned by others?	Yes	No
6. Have you had trouble with any of the following (circle all that apply): obeying the law, being irresponsible, being impulsive, being reckless, not planning ahead?		
7.Have you ever deliberately hurt or cut yourself, or threatened or attempted suicide?	Yes	No
8.Do you frequently feel empty, moody and/or angry?	Yes	No
9.Are your relationships frequently very dramatic, with lots of arguments or break ups?	Yes	No
10.Do you frequently feel anxious, nervous, tense, or jittery?	Yes	No
11.Do you frequently feel sad, blue, down, hopeless or worthless?	Yes	No
12. Have you had periods where you had so much energy you could go days without sleep & not feel tired?	Yes	No

Please list all current Medications, how long you have been taking them, and how you take them (include over-the counter meds, herbal meds, vitamins and supplements):

Indicate why you are scheduled to see Dr. Flaming: Follow-up, Physical, New Problem, Get Established.

What is the **MAIN** concern/*problem* you would like to focus on today?

_____
_____
_____

Please answer the following concerning this MAIN problem:
What's been this problem's duration in days, weeks, months or years? _____
What helps this problem? _____ What worsens it? _____
Rank the severity of this problem (1-10, 10 being the worst? _____
Where is the problem located on your body? _____
When does it occur? _____
What are YOU doing when this problem occurs (like exertion, resting, eating)?. What other symptoms do you associate with this problem? _____
_____

Describe the quality of the problem or pain (like burning, pressure, sharp, dull)

_____

IF we have time, what other concerns would you like to address? Please describe in detail:

_____
_____
_____

Do you need any medications refilled today? If yes, which ones?

_____
_____
_____

Have you had any tests, X-rays, labs, changes to your medications, consults, hospital or ER visits since (saw you last? If yes, please explain:

_____
_____
_____
_____

List new, non-minor, illnesses/health problems in your immediate family (parents, children, siblings)

_____
_____
_____

Have you ever smoked or used tobacco regularly? _____ If yes, are you still using it? _____
How much tobacco do you typically use in a day? _____ in a week? _____
How old were you when you started using tobacco? _____ If quit, how long ago did you quit tobacco? _____
How many servings of beer, wine or alcohol do you typically drink in a day? _____ in a week? _____
How many servings of caffeine do you typically have each day? _____
At what time do you have your last serving of caffeine? _____
Do you use marijuana or CBD oil? _____ How often? _____
Have you ever used street drugs or IV drugs (shot-up)? _____
Have you been sexually active in the last 12 months? _____
Do you have sex with women, men, or both? _____
Are you single, married, divorced or separated? _____

Please circle any of these symptoms that apply to you.

Constitutional
- Fever/Chills
- Feeling poorly
- Feeling tired
- Recent weight loss/gain
- Night sweats

Eyes
- Eye pain
- Red eyes/discharge
- Vision changes
- Dry eyes
- Itchy eyes

ENT
- Earache
- Sore throat
- Nasal congestion/discharge
- Nosebleeds
- Hoarseness
- Hearing loss

Cardiovascular
- Chest pain
- Irregular heartbeat
- Lower extremity edema
- Leg cramps/pain with exercise
- Slow heart rate
- Fast heart rate

Respiratory
- Shortness of breath
  Shortness of breath during exertion
- Cough
- Wheezing
- Shortness of breath while lying down/at night

Gastrointestinal
- Nausea and/or vomiting
- Abdominal pain
- Diarrhea
- Heartburn
- Constipation
- Trouble swallowing
- Dark or bloody stool

Genitourinary
- Pain with urination
- Frequency/urgency of urination
- Nighttime urination
- Hesitancy
- Incontinence (loss of urine control)
- Blood in urine
- Genital lesion
- Difficulty with menstrual periods (females)
- Erectile dysfunction (males)

Musculoskeletal
- Joint pain
- Joint swelling
- Joint stiffness
- Limb pain/swelling
- Muscle cramps/weakness

Integumentary
- Skin rash
- Itching
- Skin lesions
- Change in mole
- Breast pain/lump
- Wound /unusual growth on skin

Neurological
- Headache
- Dizziness
- Mental changes
- Fainting
- Limb weakness
- Difficulty walking
- Numbness
- Tremor
- Radiating pain

Psychiatric
- Anxiety
- Depression
- Suicidal or homicidal thoughts
- Personality changes/irritability
- Sleep disturbances

Endocrine
- Excessive thirst/urination
- Drooping of eyelid
- Hot or cold intolerance
- Hair loss
- Generalized weakness

Blood/Lymph
- Easy bruising/bleeding
- Swollen glands

Here for a physical?

Please answer the following questions:

Do you see a dentist regularly? _____
Do you see an eye doctor once a year? _____
Are your vaccines up to date? _____
Tetanus? __Flu? ___Pneumonia? ___Hepatitis? ___
Do you eat a healthy diet? _____
Do you feel the need to lose weight? _____
Do you exercise regularly? _____
Do you use Tobacco? ____ Alcohol? ____ Drugs? ____
Are you sexually active? _____
If so, do you use contraception? _____
If so, any problems? _____
Do you use seat belts regularly and drive safely? ___
Do you have smoke detectors? _____
Do you have a carbon monoxide detector? _____
What other health concerns do you have today?
_____