Luan Q. Pho, M.D., P.A.

Date _____

Name _____ Age ___ DOB _____ Sex ___ SSN _____

Weight: Now _____ One year ago _____ Maximum _____ When _____

PAST MEDICAL HISTORY

Have you ever had? (Please √)	No	Yes
Congenital Heart Disease	☐	☐
Heart Attack/Failure	☐	☐
High Blood Pressure	☐	☐
AIDS/HIV	☐	☐
Boils	☐	☐
Chicken Pox	☐	☐
Diphtheria	☐	☐
Food Poisoning	☐	☐
German Measles	☐	☐
Gonorrhea	☐	☐
Herpes	☐	☐
Measles	☐	☐
Meningitis	☐	☐
Mumps	☐	☐
Polio	☐	☐
Rheumatic Fever	☐	☐
Scarlet Fever	☐	☐
Syphilis	☐	☐
TB	☐	☐
Typhoid	☐	☐
Whooping Cough	☐	☐
Asthma	☐	☐
Pleurisy	☐	☐
Pneumonia	☐	☐
Anal Fissure	☐	☐
Crohn's Disease	☐	☐
Cystitis	☐	☐
Diabetes	☐	☐
Esophagitis	☐	☐
Gallbladder Disease	☐	☐
Gastritis	☐	☐
Hemorrhoids	☐	☐
Hepatitis	☐	☐
Hiatus Hernia	☐	☐
High Cholesterol	☐	☐
Hypoglycemia	☐	☐
Liver Disease	☐	☐
Osteoporosis	☐	☐
Peptic Ulcer	☐	☐
Pyelonephritis	☐	☐
Ulcerative Colitis	☐	☐
Anemia	☐	☐
Cancer Type:	☐	☐
Bursitis	☐	☐
Gout	☐	☐
Lupus	☐	☐
Neuritis	☐	☐
Osteoarthritis	☐	☐
Rheumatoid Arthritis	☐	☐
Epilepsy/Seizures	☐	☐
Head Injuries	☐	☐
Migraine Headaches	☐	☐
Broken Bones	☐	☐
Eczema	☐	☐
Hives	☐	☐
Mental Illness	☐	☐
Skin Disorder	☐	☐
Any other diseases/disorders	☐	☐

SURGICAL HISTORY

What surgery have you had?

Have you ever received a blood transfusion?
☐ No ☐ Yes Date:

(WOMEN ONLY)

Age of onset for menses:

Length of cycle (start to start):
☐ Regular ☐ Irregular
☐ Light ☐ Heavy
Cramps ☐ No ☐ Yes

Last Pap Smear/Pelvic Exam:

Number of Live Births:
Miscarriages:
Abortions:
C-Sections:
Complications of Pregnancy:

Do you do regular breast exam? ☐ No ☐ Yes
Date of last mammogram:
Any breast problems? ☐ No ☐ Yes
Age of onset of menopause:
Post Menopausal Problems? ☐ No ☐ Yes
Hormonal Replacement Therapy? ☐ No ☐ Yes

(MEN ONLY)

Discharge from penis? ☐ No ☐ Yes
Enlarged Prostate? ☐ No ☐ Yes
Prostate Infections? ☐ No ☐ Yes
Testicular lump(s)? ☐ No ☐ Yes

MEDICATIONS

(PRESCRIPTION AND OVER THE COUNTER)

Drug Name	Strength	Frequency

MEDICATION ALLERGIES NAME OF MEDICATION & DESCRIBE REACTION

FAMILY MEDICAL HISTORY

	State of Health	Cause of Death
Father:		
Mother:		
Siblings:		

Any relative with colon/rectal cancer? ☐ No ☐ Yes
I f yes, who:

Has any blood relative ever had: (Please √)	No	Yes
Cancer type:	☐	☐
Colitis	☐	☐
Diabetes	☐	☐
Heart Trouble	☐	☐
High blood pressure	☐	☐
Stroke	☐	☐
Liver disease	☐	☐
Ulcer disease	☐	☐
Gallbladder disease	☐	☐

SOCIAL HISTORY

Do you smoke? ☐ No ☐ Yes
What?
How long?
How many per day?

Do you drink alcoholic beverages? ☐ No ☐ Yes
What?
How much per week?

Recreational drugs ☐ No ☐ Yes
IV drugs ☐ No ☐ Yes

Do you have any tattoos? ☐ No ☐ Yes
Have you ever been treated for alcoholism or drug habit? ☐ No ☐ Yes

Are you: ☐ married ☐ divorced ☐ widowed
Do you live with your spouse? ☐ No ☐ Yes
How many children do you have?

Luan Q. Pho, M.D., P.A.

Date _____

Name _____ Age ___ DOB _____ Sex ___ SSN _____

REVIEW OF SYMPTOMS

Do you have or have you had any of the following in the past year?

(Please √)	No	Yes
Headache	☐	☐
Fainting	☐	☐
Dizziness	☐	☐
Blurred Vision	☐	☐
Double Vision	☐	☐
Spots before eyes	☐	☐
Conjunctivitis	☐	☐
Change in Vision	☐	☐
Do you wear eyeglasses/contact lenses?	☐	☐
Date of last eye exam:		
Earaches	☐	☐
Discharge from ears	☐	☐
Ringing in ears	☐	☐
Decreased hearing	☐	☐
Nosebleeds	☐	☐
Frequent head colds	☐	☐
Sinusitis	☐	☐
Hay Fever	☐	☐
Strange, persistent odors	☐	☐
Strange taste	☐	☐
Loss of taste	☐	☐
Persistent Laryngitis	☐	☐
Enlarged glands	☐	☐
Recurrent sore throats	☐	☐
Recurrent sores in mouth	☐	☐
Soreness or bleeding of gums on brushing	☐	☐
Chest pain	☐	☐
Angina	☐	☐
Coughing up blood	☐	☐
Pain in arm(s)	☐	☐
Night sweats	☐	☐
Chronic or frequent cough:	☐	☐
Productive	☐	☐
Dry	☐	☐
Shortness of breath:	☐	☐
Wakes you up	☐	☐
On walking several blocks	☐	☐
On walking one flight of stairs	☐	☐
On lying down	☐	☐
Purple lips or fingers	☐	☐
Palpitations or fluttering of heart	☐	☐
High blood pressure	☐	☐
Swelling of hands, feet or ankles:	☐	☐
At what time of day:	☐	☐
Leg cramps:	☐	☐
On walking	☐	☐
At night	☐	☐
Enlarged veins in legs	☐	☐
Recurrent stomach pain	☐	☐
Belching, heartburn, indigestion	☐	☐
Trouble swallowing		
Appetite: ☐ Good ☐ Fair ☐ Poor	☐	☐
Nausea	☐	☐
Vomiting	☐	☐
Avoidance of any foods	☐	☐
Cramping	☐	☐
Abdominal pain	☐	☐
Diarrhea	☐	☐
Constipation	☐	☐
Blood in stool	☐	☐

(Please √)	No	Yes
Rectal pain	☐	☐
Difficulty in urination	☐	☐
Do you get up at night to urinate	☐	☐
How many times?		
Any blood in urine	☐	☐
Lose urine on coughing or sneezing	☐	☐
Backaches	☐	☐
Joint pain or swelling	☐	☐
Tingling or weakness of hands or feet	☐	☐
Loss or change in sensation of hands or feet	☐	☐
Trembling of any extremity	☐	☐
Growth in neck or throat	☐	☐
Hot flashes	☐	☐
Dryness of skin	☐	☐
Easy bruising	☐	☐
Inability to stand heat/cold	☐	☐
Change in hair texture	☐	☐
Change in skin texture	☐	☐
Any skin rash	☐	☐
Positive TB skin test	☐	☐
Mental illness	☐	☐

IMMUNIZATIONS

(Please √)	No	Yes	Date
Flu	☐	☐	
Pneumonia	☐	☐	
Hepatitis A	☐	☐	
Hepatitis B	☐	☐	
Tetanus	☐	☐	

Current Physician(s)
Previous Physician(s)