Patient Name: ________________________________ Date: ______________________

YourMD

S. William Pierce, MD

Symptoms Check symptoms you currently have or have had in the past few months.

General
__Fever
__Chills
__Sweats
__Night Sweats
__Fatigue
__Fainting
__Body Aches
__Headache
__Anxiety
__Memory Loss
__Suicidal Thoughts
__Hallucination
__Insomnia
__Depression
__Thirsty All the Time
__Weakness

Gastrointestinal/Endo
__Nausea
__Vomiting (__Bloody)
__Diarrhea
__Constipation
__Change in Bowel Habits
__Abdominal Pain
__Bloody Stools
__Black/Tarry Stools
__Jaundice (yellow skin)
__Hemorrhoids
__Indigestion
__Stomach pain
__Cold/Heat Intolerance
__Chronic Nasal Congestion
__Drinking Large Volumes of Fluids
__Weight Change

Eye, Ear, Nose, Throat
__Blurring of Vision
__Sensitivity to Light
__Eye Pain
__Vision loss/changes
__Eye Discharge
__Eye Irritation/Itching
__Seeing Double
__Ear Pain/Discharge
__Swallowing Difficulties
__Hoarseness
__Sore Throat
__Nosebleeds
__Nasal Discharge
__Decreased Hearing
__Ringing in Ears
__Sinus Problems

MEN Only
__Breast Lump
__Breast Enlargement
__Breast Tenderness
__Lump in Testicles
__Penis Discharge
__Sore on Genitals
__Dec Urine Flow
__ Problems with Erections
__Other

Respiratory
__Cough
__Shortness of Breath
__Excessive Sputum
__Coughing Up Blood
__Wheezing

Muscle/Bone/Joint
Pain or Numbness in:
(Please Circle and √Location)

__Back	__Legs
__Feet	__Neck
__Hands	__Shoulders
__Knees	__Arms
__Hips	

Cardiovascular
__Chest Pain
__Heart Palpitations
__Passing Out
__Shortness of Breath on Exertion
__Shortness of Breath While Lying
__Nighttime Shortness of Breath
__Swelling of ankles
__Low Blood Pressure
__Varicose veins
__High Blood Pressure

Skin
__Bruise easily
__Itching
__Hives
__Rash
__Change in Moles
__Scars
__Sore that Won't Heal

Urinary
__Painful Urination
__Blood/Dark Urine
__Loss of Bladder Control/Leaking
__Urinary Urgency
__Frequent Urination

List all medications with dosage you are currently taking:
____
____
____
____
____
____

MEDICATION ALLERGIES
____
____

RELIGIOUS PREFERENCE ________________
ADVANCED DIRECTIVES? N__Y__please provide

Patient Signature: ____________________________
Date: __________________

Dr. Initial: ________

FOR WOMEN:
Date of last Menstrual Period______
Date of last Pap smear__________
Date of last Mammogram__________
Are you pregnant? ___________
Number of children_____________
__Vaginal Discharge
__Abnormal Pap smear
__Bleeding between periods
__Breast Lump
__Extreme menstrual pain
__Hot Flashes
__Nipple Discharge
__Painful Intercourse
__Other

VACCINATIONS:
Are all shots up to date? YES NO UNSURE

FAMILY HISTORY Fill in health information about your family **RELATION**	**AGE**	**STATE OF HEALTH**	**AGE AT DEATH**	**CAUSE OF DEATH**
Father				
Mother				
Brothers				
Sisters				
Paternal Grandfather				
Paternal Grandmother				
Maternal Grandfather				
Maternal Grandmother				
Paternal Uncle				
Paternal Aunt				
Maternal Uncle				
Maternal Aunt				
Children				

PROBLEMS/ILLNESS/SURGERY	**DATE**	**OUTCOME**

HEALTH HABITS: Check which substances You use and describe how much you use:

__Caffeine______________________

__Tobacco______________________

__Alcohol________________________

__Illicit Drugs____________________

__Marijuana (which form)____________

Date of Last Tetanus: ______________

Date of Last EKG: ________________

Date of Last Colonoscopy_________

Date of Last Chest X-ray__________

Date of Last Physical/Annual Exam__

Patient Signature: ________________

Date: ___________________________

Physician Signature: ______________

Date: ___________________________