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
__Fatigue
__Fainting
__Body Aches
__Headache
__Anxiety
__Memory Loss
__Suicidal Thoughts
__Hallucination
__Insomnia
__Depression
__Dizziness
__Cold/Heat Intolerance

**Gastrointestinal/Endo**
__Nausea
__Vomiting (__bloody)
__Diarrhea
__Constipation
__Change in Bowel Habits
__Abdominal Pain
__Bloody Stools
__Black/Tarry Stools
__Jaundice
__ Hemorrhoids
__Indigestion
__ Stomach pain
__**Drinking Large Volume of Fluids**
__Thirsty All the Time
__Weight Change

**Eye, Ear, Nose, Throat**
__Blurring of Vision
__Sensitivity to Light
__Eye Pain
__Vision Loss/Changes
__Eye Discharge
__Eye Irritation/Itching
__Seeing Double/Multiple
__Ear Pain/Discharge
__Swallowing Difficulties
__Hoarseness
__Sore Throat
__Nosebleeds
__Nasal Discharge
__Chronic Nasal Congestion
__Decreased Hearing
__Ringing in Ears
__Sinus Problems

**MEN Only**
__Breast lump
__Problems with Erections
__Changes to Genitals
__Lump in testicles
__Penis Discharge
__Sores on Genitals
__Dec Urine Flow
__Other

**Muscle/Bone/Joint**
Pain, weakness or: numbness in (Circle)
__Arms __Hips
__Back __Legs
__Feet __Neck
__Hands __Shoulders

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

**Skin**
__Change in skin color
__Bruise easily
__Hives/Itching
__Dry Skin
__Change in Moles
__Rash
__Scars
__Sore that won't heal

**Respiratory**
__Painful Breathing
__Cough
__Shortness of Breath
__Excessive Sputum
__Coughing Up Blood
__Wheezing

**Urinary**
__Change in Urine color
__Painful Urination
__Blood in Urine
__Loss of bladder control
__Urinary Urgency
__Urinary Frequency

**List all medications with dosage you are currently taking:**
_____
_____
_____
_____
_____
_____

**MEDICATION ALLERGIES**
_____
_____

**RELIGIOUS PREFERENCE _____**
**ADVANCED DIRECTIVES? N__Y__**please provide

**FOR WOMEN:**
Date of last Menstrual Period_____
Date of last Pap smear_____
Date of last Mammogram_____
Are you pregnant? _____
Number of children_____

__Abnormal Pap smear
__Bleeding between periods
__Breast Lump
__Extreme menstrual pain
__Hot Flashes
__Nipple Discharge
__Painful Intercourse
__Vaginal Discharge
__Other

Patient Signature: _____
Date: _____

**FOR CHILDREN**:
Are all shots up to date? _____
If not, please explain: _____

Dr. Initial: _____

**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** | | | | |
| | | | | |
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| PROBLEMS/ILLNESS/SURGERY | DATE | OUTCOME |
|---|---|---|
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| | | |
| | | |

**HEALTH HABITS**: Check
Which substances you use and
Describe how much you use:
__Caffeine_____
__Tobacco_____
__Alcohol_____
__Drugs_____
_____

**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: _____