



**MASONBORO FAMILY MEDICINE**  
**CURRENT HEALTH/ SYMPTOMS**

**CURRENT HEALTH CONDITIONS:**

- |   |   |
|---|---|
| <input type="checkbox"/> Alcoholism       | <input type="checkbox"/> HIV/Aids             |
| <input type="checkbox"/> Anemia           | <input type="checkbox"/> Irregular Heart Beat |
| <input type="checkbox"/> Anorexia         | <input type="checkbox"/> Insomnia             |
| <input type="checkbox"/> Anxiety          | <input type="checkbox"/> Kidney Disease       |
| <input type="checkbox"/> Arthritis        | <input type="checkbox"/> Liver Disease        |
| <input type="checkbox"/> Asthma           | <input type="checkbox"/> Migraine Headaches   |
| <input type="checkbox"/> Cancer           | <input type="checkbox"/> Pacemaker            |
| <input type="checkbox"/> COPD             | <input type="checkbox"/> Prostate Problems    |
| <input type="checkbox"/> Cataracts        | <input type="checkbox"/> Psychiatric Care     |
| <input type="checkbox"/> Depression       | <input type="checkbox"/> Thyroid Problems     |
| <input type="checkbox"/> Diabetes         | <input type="checkbox"/> Tuberculosis         |
| <input type="checkbox"/> Drug Addiction   | <input type="checkbox"/> Ulcers               |
| <input type="checkbox"/> Emphysema        | Other: _____                                  |
| <input type="checkbox"/> Epilepsy         |   |
| <input type="checkbox"/> GERD/ Reflux     |   |
| <input type="checkbox"/> Glaucoma         |   |
| <input type="checkbox"/> Goiter           |   |
| <input type="checkbox"/> Gout             |   |
| <input type="checkbox"/> Heart Disease    |   |
| <input type="checkbox"/> Hepatitis        |   |
| <input type="checkbox"/> HTN              |   |
| <input type="checkbox"/> High Cholesterol |   |

**Have you ever had a blood transfusion? Y/N Date: \_\_\_\_\_**

**Have you had a Tetanus shot in the last 10 years? Y/N Date: \_\_\_\_\_**

**Have you had a Pneumonia shot in the past 7 years? Y/N Date: \_\_\_\_\_**

**Did you get a Flu shot last year? Y/N**

**PHARMACY: \_\_\_\_\_**

I certify that the above information is correct to the best of my knowledge; I will not hold my Provider or any members of his/her staff responsible for any errors or omissions that I may have made in completion of this form.

Pt signature: \_\_\_\_\_ Date: \_\_\_\_\_

Reviewed by: \_\_\_\_\_ Date: \_\_\_\_\_

**MASONBORO FAMILY MEDICINE**  
CURRENT SYMPTOMS

**SYMPTOMS:** Mark the symptoms you currently have or have had in the past month.

**GENERAL:**

- Chills
- Fever
- Depression
- Dizzy/Light headed
- Headaches
- Fatigue
- Wt gain/ Wt loss
- Nervousness
- Insomnia
- Night Sweats
- Change in Libido

**GASTROINTESTINAL:**

- Decrease/Increased Appetite
- Increased Thirst
- Excessive Gas/ Bloating
- Indigestion
- Nausea/ Vomiting/ Diarrhea
- Dark/Tarry stools
- Constipation
- Rectal bleeding
- Hemorrhoids
- Abdominal Pain

**EAR, EYES, NOSE THROAT**

- Vision changes/ Blurred/ Doubled
- Difficulty swallowing
- Ear discharge/ pain
- Hearing Loss
- Ringing in Ears
- Sinus Pressure
- Nose Bleeds
- Seasonal Allergies

**GENITOURINARY**

- Frequent Urination
- Painful Urination
- Difficulty Urinating
- Lack of Bladder Control
- Poor emptying of Bladder

**HEART/LUNGS**

- Low / High Blood Pressure
- Chest Pain
- Short of Breath
- Racing Heart
- Swelling of ankles/legs
- Poor Circulation
- Nonproductive/ Productive Cough
- Persistent Cough
- Wheezing

**SKIN**

- Itching     Rash     Hives
- Change In freckles/ Moles
- Sore that will not heal

**MUSCLE/JOINT/BONE**

- Pain, weakness or numbness in:
- Shoulder     Feet     Hips
  - Arms/ Elbow     Legs     Neck
  - Hands     Knee     Back

**MEN ONLY**

- Breast Lump     Hernia
- Testicle Lump
- Penis Discharge
- Sore on Penis

**WOMEN ONLY**

- Abnormal Bleeding/ PAP
- Bleeding between periods
- Extreme Menses Pain
- Vaginal Discharge
- Painful Intercourse
- Hot Flashes
- Breast Lump     Nipple discharge

**REVIEWED BY:** \_\_\_\_\_ **DATE:** \_\_\_\_\_

