DR KEDY JAO

ANTI-AGING AND FAMILY MEDICINE

ROUTINE HEALTH ASSESSMENT - FAMILY/PERSONAL HISTORY

Name		Age		Date of Birth		Date	
Marital Status	Single Married Domestic Partner Divorced Widowed			Birth Place			

LIVING	MEDICAL CONDITIONS	DECEASED	CAUSE OF DEATH
Father: _____ Age		_____ Age at death	
Mother: _____ Age		_____ Age at death	
Sibling 1: _____ Age (Bros/Sis)		_____ Age at death	
Sibling 2: _____ Age (Bros/Sis)		_____ Age at death	
Child 1: _____ Age (M / F)		_____ Age at death	
Child 2: _____ Age (M / F)		_____ Age at death	

List blood relatives medical illnesses: *(eg Cancer, Leukemia, Diabetes, Hearth Trouble, High Blood Pressure, Stroke, Epilepsy, Thyroid, Alcoholism, Tuberculosis, Suicide)*

Relative:		Relative:	

SOCIAL HISTORY		
Education Level _______ yrs in High School, _______ yrs in College		
Do you use a seatbelt? Do you use a helmet?		
Do you smoke cigarettes? If so, _____ packs per day		
If you smoked in the past, for ______ years and I quit on _____/_____/_____		
Do you use: Cigars Pipe Chewing Tobacco Snuff		
Alcoholic Beverages: Never Rarely Moderate Daily		
Have you ever wanted help with alcohol now or in the past?	Y	N
Do you use recreational drugs?	Y	N
Do you or your partner use IV drugs?	Y	N
Have you ever wanted help with drugs now or in the past?	Y	N
Are you sexually active now? Vaginal Anal Oral		
Have you had more than 1, or a new, partner in the past year?	Y	N
Is/are your partner(s): Male Female Both		
Have you ever been hit or pushed by a partner?	Y	N
Do you take precautions against STD'S?	Y	N
Have you been put at risk for STD or HIV?	Y	N
Do you wish to have an HIV test?	Y	N
Have you ever had a tattoo?	Y	N
Do you have an Advance Directive (Living Will)?	Y	N
If not, would you like information?	Y	N

PAST MEDICAL HISTORY		
Any broken bones, dislocations or head injuries?	Y	N
Any serious accidents?	Y	N
SURGICAL HISTORY (Select all that apply)		
Tonsillectomy Appendectomy Hysterectomy		
Gall Bladder Removed Ovaries Removed Mastectomy		
Breast Lump Removed Other:___________________________		
Have you been hospitalized for any illness?	Y	N
If so, why?		
CONDITIONS (Select all that apply)		
Cancer High Blood Pressure Heart Disease Diabetes Depressions Lung Disease Arthritis or Rheumatism Migraines Anemia Jaundice/Liver Disease STDS Seizures/Convulsions Rheumatic Fever Meningitis Tuberculosis or + TB Test Any Bone or Joint Disease Kidney Disease Kidney Stones Hay Fever Measles Hives/Eczema Mumps Chicken Pox Whooping Cough Pneumonia Polio Freq Infections/Boils Skin Disease Freq Colds or Sore Throats Blood Transfusions		
Weight at age 18? ____ Maximum weight ____ When? _________		
PREGNANCY HISTORY		
# of Pregnancies ____ # Living Children ____ # of Deliveries ____ # of C-Sections ____ # of Abortions ____ # Miscarriages ____ # of Tubal Pregnancies ____ Any pregnancy complications? ____		

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ALERGIES	REACTION	MEDICATIONS (List strength and frequency)	
Penicillin or Sulfa		1)	
Erthromycin		2)	
Aspirin, Codeine, Morphine		3)	
Iodine		4)	
Adhesive Tape		5)	
Any foods or other drugs		6)	

CONSTITUTIONAL SYMPTOMS			GASTROINTESTINAL			NEUROLOGICAL		
Fever	Y	N	Stomach trouble or ulcer	Y	N	Headache __Freqent __Severe	Y	N
Chills	Y	N	Nausea or vomitting	Y	N	Dizziness	Y	N
Night sweats	Y	N	Heartburn/indigestions	Y	N	Numbness	Y	N
Extreme tiredness	Y	N	Constipation	Y	N	Paralysis	Y	N
Recent weight change	Y	N	Diarrhea	Y	N	Fainting	Y	N
Change in appetite	Y	N	Hemorrhoid/rectal bleed	Y	N	Loss of consciousness	Y	N
EYES, EARS, NOSE & THROAT			Black Stool	Y	N	Seizure	Y	N
Blurred vision	Y	N	Difficulty swallowing	Y	N	MENTAL HEALTH		
Double vision	Y	N	Do you take laxatives?	Y	N	Anxiety	Y	N
Ear pain	Y	N	Change in bowel habits	Y	N	Hallucinations	Y	N
Ringing in the ears	Y	N	GENITOURINARY			Treated for mental disorder	Y	N
Hearing loss	Y	N	Kidney disease or stones	Y	N	Feeling down or depressed	Y	N
Nasal discharge	Y	N	Painful urination	Y	N	Lack interest/pleasure	Y	N
Sore throat	Y	N	Blood in urine	Y	N	HABITS		
CARDIOVASCULAR			Frequent urination	Y	N	Trouble sleeping	Y	N
Chest pain	Y	N	Frequent urination at night	Y	N	Exercise	Y	N
Palpitations	Y	N	SKIN			MEN ONLY		
Hand/feet/ankle swelling	Y	N	Rash	Y	N	Conduct testicular exams	Y	N
RESPIRATORY			Itching	Y	N	Erectile problems?	Y	N
Cough __chronic __frequent	Y	N	HEMATOLOGIC			WOMEN ONLY		
Coughing up blood	Y	N	Easy bleeding	Y	N	Conduct breast exams	Y	N
Shortness of breath	Y	N	ENDOCRINE			Date of last period		
Stop breathing with sleep	Y	N	Abnormal thirst	Y	N	Regular periods?	Y	N
MUCULOSKELETAL			Excessive urine volume	Y	N	Usual length length in days		
Paint in joints	Y	N	Eat excessively	Y	N	Cycle ______ days		
Back pain	Y	N	Hot flashes	Y	N	Pain or cramps	Y	N
Muscle pain	Y	N	Thyroid problems	Y	N	Abnormal vaginal discharge	Y	N