Robert O. Wilson, MD, MS, FACOG

6327 N. Fresno St. #101 Fresno, CA 93710 (559) 435-5252

Date ______________

Name: ______________________________

Age: __________

Home phone: ______________________________
Work phone: ______________________________
Cell phone: ______________________________
email: ______________________________

Occupation: ______________________________
Primary care physician: ______________________________
How would you like to be contacted with test results?
Home phone ◻ Cell phone ◻ OK to leave results ◻ No results on voice mail ◻

1 **List any concerns or problems you are currently experiencing:**

____
____
____

2 **List other physicians you have seen since your last visit:**

____
____

3 **List any surgeries, hospitalizations or illnesses since your last visit:**

____
____

4 **List your current medications including over-the-counter, herbal, vitamins & minerals:**

____
____
____

Allergies to medications ______________________________
Any other allergies ______________________________

5 **Family History Update**
Are there any new significant illnesses or deaths in the family? Yes ◻ No ◻

6 **Social History**
Married ◻ Single ◻ Widowed ◻ Divorced ◻ Separated ◻
If married, how many years? ____________
Quality of relationship: Good ◻ Okay ◻ Poor ◻
Do you smoke? Yes ◻ No ◻ Second hand smoke exposure? Yes ◻ No ◻
Alcohol: If you drink, how often? ____________
Exercise: How often? ____________

7 **Review of systems** (Check positive responses)

General: Weight change ◻ Weakness ◻ Fatigue ◻ Fever ◻
Hot flashes ◻ Night sweats ◻ Insomnia ◻
Skin: Rashes ◻ Change in a mole(s) ◻ Bruise easily ◻ Skin problems ◻
HEENT: Dizziness ◻ Hearing loss ◻ Bloody noses ◻ Trouble swallowing ◻
Sore throats ◻ Sinus-allergy problems ◻ Last dental visit ______ Last eye exam ______
Breast: Monthly self-breast exams ◻ New masses, tenderness ◻ Bra cup size ______
Cardiovascular: Palpitations ◻ Chest pain ◻ Edema or swelling ◻
Respiratory: Cough ◻ Wheezing ◻ Shortness of breath ◻
GI: Nausea ◻ Vomiting ◻ Diarrhea ◻ Constipation ◻
Abdominal pain ◻ Blood in stool ◻ Hemorrhoids ◻
Urinary: Frequency ◻ Urgency ◻ Burning ◻ Up at night to urinate ◻ Incontinence ◻
Musculoskeletal: Joint pain ◻ Swelling ◻ Back pain ◻ Injuries ◻
Neurological: Memory loss ◻ Numbness ◻ Headaches ◻ Migraines ◻
Psychosocial: Depression ◻ Anxiety ◻ Moody ◻ Panic Attacks ◻
Domestic Violence: Have you been kicked, hit, slapped or touched inappropriately
or any other type of abuse at work or at home? Yes ◻ No ◻
Blood Donation: Have you donated since your last annual exam? Yes ◻ No ◻