RANDALL MAXEY, MD, PhD

Advanced Community Medical Care Corporation
418 E Arbor Vitae St Inglewood, CA 90301
Phone: 310-680-1810

Date: ____/_____/____

Name: _____ Sex ____ D.O.B: _____ Age___

Occupation: _____ Marital Status _____

NAME OF PERSON WHO REFERRED YOU _____

PART A-PRESENT HEALTH HISTORY

I.CURRENT MEDICAL PROBLEMS

Please list the medical problems for which you came to see the doctor. About when did they begin?

Problems	**Date Began**
_____	_____
_____	_____
_____	_____

What concerns you most about these problems?

_____

_____

If you are being treated for any other illnesses or medical problems by another Physicians, please describe the problems and write the name of the Physicians or medical facility treating you.

Illness or Medical Problems	**Physician or Medical Facility**	**City**
_____	_____	_____
_____	_____	_____

II. MEDICATIONS

Please list all medications you are currently taking, including those you buy without a doctor's prescription such as (aspirin, cold tablets or vitamin supplement)

1. _____ **3.** _____ **5.** _____
2. _____ **4.** _____ **6.** _____

IV. ALLERGIES & SENSITIVITIES

List anything that you are allergic to such as certain foods, medications, dust, chemicals, or soaps, household items, pollens, bee stings, etc., and indicate how each affects you.

Allergic to:	Effect:	Allergic to:	Effect:
1. _____	_____	3. _____	_____
2. _____	_____	4. _____	_____

IV GENERAL HEALTH, ATTITUDE AND HABITS

How is your overall health now? Poor ___ Fair ___ Good ___ Excellent ___
How has it been most of your life? Poor ___ Fair ___ Good ___ Excellent ___
In the past year:
Has your appetite changed? Decreased ___ Increased ___ Stayed same ___
Has your weight changed? Lost ___ lbs Gained ___ lbs No change ___
Are you thirsty most of the time? No ___ Yes ___
Has your overall 'prep' changed? Decreased ___ Increased ___ Stayed same ___
Do you usually have trouble sleeping? No ___ Yes ___
How much do you exercise? Little or None ___ Less than I need ___ All I need ___
Have you ever had a problem with alcohol? No ___ Yes ___
How much coffee or tea do you usually drink? _____ cups of coffee or tea a day
Do you regularly wear seatbelts? No ___ Yes ___

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PAST MEDICAL HISTORY

Hospitalization: LIST ALL HOSPITALIZATION WITH DATE/S & REASON/S.

Occupation: JOB TITLE: _____
HOW LONG ON THIS JOB?_____
IF RETIRED OR DISABLED, WHEN LAST WORKED? _____

Surgery: LIST ALL SURGERY DATE/S, REASON/S, IF NONE PLEASE STATE "NONE"

Prescription: LIST ALL MEDICATIONS & DOSAGE, HERBS OR NON-PRESCRIPTION DRUGS & HOME REMEDIES YOU ARE TAKING

Illness/es: ANY CHRONIC ILLNESS/ES (DIABETES, HYPERTENSION, PEPTIC ULCER, ASTHMA, ETC)

Toxic Exposure: LIST ANY TOXIC EXPOSURE FROM JOB OR HOME.

LIST ANY INJURIES (FRACTURES, SPRAINS, CAR ACCIDENTS, ETC)

ANY BLOOD TRANSFUSION: WHEN _____
HOW MANY UNITS_____

Allergy: ANY DRUG ALLERGIES, FOOD ALLERGIES, HISTORY OF HIVES OR LUPUS

Legal: ANY WORKERS' COMPENSATION IN THE PAST OR PENDING

ANY LIMITATION OF ABILITY TO FUNCTION AS DESIRES AS A RESULT OF PAST EVEN OR DISABLING INJURY/ILLNESS.

HOW HAS YOUR HEALTH BEEN IN THE PAST 5 YEARS:
EXCELLENT ___ GOOD ___ FAIR ___ POOR ___

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DO YOU:	**Rare/Never**	**Occasionally**	**Frequently**
Feel nervous?	_____	_____	____
Use marijuana?	_____	_____	____
Feel depressed?	_____	_____	____
Use "hard drugs"?	_____	_____	____
Find it hard to make decisions?	_____	_____	____
Sexual problems?	_____	_____	____
Lose your temper?	_____	_____	____
Trouble relaxing?	_____	_____	____
Worry a lot?	_____	_____	____
Tire easily?	_____	_____	____
Ever feel like Committing suicide?	_____	_____	____
Feel bored with your life?	____	_____	____

Do you want to talk to the doctor about a personal matter?
No ____ Yes _____

Have you recently had any changes in your:
Marital status? No __ Yes __
Job or Work? No __ Yes __
Residence? No __ Yes __
Financial status? No __ Yes __
Are you having any legal problems? No __ Yes __

If yes, please explain:

_____
_____
_____
_____
_____

Any Behavioral/Job risk for HIV exposure? No ___ Yes___
If yes, Please explain _____
_____
_____

Is your immunization status current? No ___ Yes___
If no, Please give year _____ & Type _____ of last immunization received.

FOR DOCTOR'S COMMENT ONLY:

_____
_____
_____

I.ILLNESS & MEDICAL PROBLEMS

PLEASE MARK WITH AN (X) ANY OF THE FOLLOWING.

LLNESS	**(X)**	**YEAR**
Eye Infection	___	_____
Glaucoma	___	_____
Ear trouble	___	_____
Deafness	___	_____
Thyroid trouble	___	_____
Strep throat	___	_____
Bronchitis	___	_____
Emphysema	___	_____
Pneumonia	___	_____
Allergies/Asthma	___	_____
Tuberculosis	___	_____
Lung problems	___	_____
High blood pressure	___	_____
Heart attack	___	_____
High cholesterol	___	_____
Arteriosclerosis	___	_____
Heart murmur	___	_____
Other heart conditions	___	_____
Stomach/duodenal ulcer	___	_____
Diverticulitis	___	_____
Colitis	___	_____
Other bowel problems	___	_____
Hepatitis	___	_____
Liver trouble	___	_____
Gallbladder trouble	___	_____
Hernia	___	_____
Hemorrhoids	___	_____
Kidney or bladder disease	___	_____
Prostate problems	___	_____
Mental problems	___	_____
Headaches	___	_____
Head injury	___	_____
Stroke	___	_____
Convulsions, seizures	___	_____
Arthritis	___	_____
Gout	___	_____
Cancer or tumor	___	_____
Bleeding tendency	___	_____
Diabetes	___	_____
Measles/Rubella	___	_____
German Measles/ Rubella	___	_____
Mumps	___	_____
Scarlet fever	___	_____
Chicken pox	___	_____
Eczema	___	_____
Psoriasis	___	_____
Venereal Disease	___	_____

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MEN: *Please answer questions **1-11** and then skip to question **18**.*
WOMEN: *Please start on question **5**.*

MEN ONLY:

1. Have you had or do you have prostate trouble? No ___ Yes ___
2. Do you have any sexual problems or with impotency? No ___ Yes ___
3. Have you ever had sores or lesions on your penis? No ___ Yes ___
4. Do you ever have pain, lumps or swelling in your testicles? No ___ Yes ___

5. Is it sometimes hard to start urine flow? Rarely/Never____ Occasionally ___ Frequently ____
6. Is urination ever painful? Rarely/Never____ Occasionally ___ Frequently ____
7. Do you have to urinate more than 5 times a day? Rarely/Never____ Occasionally ___ Frequently ____
8. Do you get up at night to urinate? Rarely/Never____ Occasionally ___ Frequently ____
9. Has your urine ever been bloody or dark colored? Rarely/Never____ Occasionally ___ Frequently ____
10. Do you ever lose urine when you strain, Laugh, cough, or sneeze? Rarely/Never____ Occasionally ___ Frequently ____
11. Do you ever lose urine during sleep? Rarely/Never____ Occasionally ___ Frequently ____

WOMEN ONLY:

12. A. Have any menstrual problems? Rarely/Never____ Occasionally ___ Frequently ____
B. Feel rather tense just before your period? Rarely/Never____ Occasionally ___ Frequently ____
C. Have heavy menstrual bleeding? Rarely/Never____ Occasionally ___ Frequently ____
D. Have painful menstrual periods? Rarely/Never____ Occasionally ___ Frequently ____
E. Have bleeding between periods? Rarely/Never____ Occasionally ___ Frequently ____
F. Have any unusual vaginal discharge or itching? Rarely/Never____ Occasionally ___ Frequently ____
G. Ever have tender breast? Rarely/Never____ Occasionally ___ Frequently ____
H. Have any discharge from your nipples? Rarely/Never____ Occasionally ___ Frequently ____
I. Have any hot flashes? Rarely/Never____ Occasionally ___ Frequently ____

13. How many times, if any, have you been pregnant? _____
14. How many children born alive? _____
15. Are you taking birth control pills? Yes___ No___
16. Do you examine your breasts for lumps every month? Rarely/Never____ Occasionally ___ Frequently ____
17. What was the date of your last menstrual period? _____

MEN & WOMEN

18. In the past year have you had any:
    a. Severe shoulder pain? Rarely/Never____ Occasionally ___ Frequently ____
    b. Severe back pain? Rarely/Never____ Occasionally ___ Frequently ____
    c. Muscle or joint stiffness? Rarely/Never____ Occasionally ___ Frequently ____
    d. Pain or swelling in any joints? Rarely/Never____ Occasionally ___ Frequently ____

19. Do you have dry skin or brittle fingernails? Rarely/Never____ Occasionally ___ Frequently ____
20. Do you bruise easily? Rarely/Never____ Occasionally ___ Frequently ____
21. Do you have any moles that have changed in color or in size? Rarely/Never____ Occasionally ___ Frequently ____
22. Do you have any other skin problems? Rarely/Never____ Occasionally ___ Frequently ____
23. In the last 3 months have you had:
    a. A fever that lasted more than one day? Rarely/Never____ Occasionally ___ Frequently ____
    b. Sores or cut that was hard to heal? Rarely/Never____ Occasionally ___ Frequently ____
    c. Any cold sores (fever blisters)? Rarely/Never____ Occasionally ___ Frequently ____
    d. Any lumps in your neck, armpits or groin? Rarely/Never____ Occasionally ___ Frequently ____
    e. Do you ever have chills or sweats at night? Rarely/Never____ Occasionally ___ Frequently ____

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24. Have you traveled out of the country in the last 2 years?
25. Write in the dates for the shots you had: **Measles** ___/___/___ **Smallpox** ___/___/___ **Mumps** ___/___/___ **Polio** ___/___/___ **Tetanus** ___/___/____
26. Have you had a Tuberculin (TB) skin test? No ___ Yes ___ Date: ___/____/____
27. Do you wear eyeglasses? No ___ Yes ___
28. Do you wear contact lenses? No ___ Yes ___
29. Has your vision changed in the last year? No ___ Yes ___
30. How often do you have:
a. Double vision? Rarely/Never____ Occasionally ___ Frequently ____
b. Blurry vision? Rarely/Never____ Occasionally ___ Frequently ____
c. Watery or itchy eyes? Rarely/Never____ Occasionally ___ Frequently ____
31. Do you ever see colored rings around lights? Rarely/Never____ Occasionally ___ Frequently ____
32. Do others tell you, you have a hearing problem? Rarely/Never____ Occasionally ___ Frequently ____
33. Do you have trouble keeping your balance? Rarely/Never____ Occasionally ___ Frequently ____
34. Do you have any discharge from your ears? Rarely/Never____ Occasionally ___ Frequently ____
35. Do you ever feel dizzy or have motion sickness? Rarely/Never____ Occasionally ___ Frequently ____
36. Do you have any problems with your hearing? Rarely/Never____ Occasionally ___ Frequently ____
37. Do you ever have ringing in your ears? Rarely/Never____ Occasionally ___ Frequently ____
38. How often do you have?
A. Head colds? Rarely/Never____ Occasionally ___ Frequently ____
B. Chest colds? Rarely/Never____ Occasionally ___ Frequently ____
C. Runny nose? Rarely/Never____ Occasionally ___ Frequently ____
D. Stuffed up nose? Rarely/Never____ Occasionally ___ Frequently ____
E. Sore/hoarse throat? Rarely/Never____ Occasionally ___ Frequently ____
F. Bad coughing spells? Rarely/Never____ Occasionally ___ Frequently ____
G. Sneezing spells? Rarely/Never____ Occasionally ___ Frequently ____
H. Trouble breathing? Rarely/Never____ Occasionally ___ Frequently ____
I. Nose bleeds? Rarely/Never____ Occasionally ___ Frequently ____
J. Coughs blood? Rarely/Never____ Occasionally ___ Frequently ____
39. Have you ever worked or spent time:
A. On a farm? No ___ Yes ___
B. In a mine? No ___ Yes ___
C. In a laundry or mill? No ___ Yes ___
D. In a very dusty place? No ___ Yes ___
E. With or near toxic chemicals? No ___ Yes ___
F. With or near radioactive materials? No ___ Yes ___
G. With or near asbestos? No ___ Yes ___
40. Do you get out of breath easily when you are active? Rarely/Never____ Occasionally ___ Frequently ____
41. Do you ever feel light-headed or dizzy? Rarely/Never____ Occasionally ___ Frequently ____
42. Have you ever fainted or passed out? Rarely/Never____ Occasionally ___ Frequently ____
43. Do you sometimes feel your heart is racing or beating too fast? Rarely/Never____ Occasionally ___ Frequently ____
44. When you exercise, do you ever get pains in the chest or shoulders? Rarely/Never____ Occasionally ___ Frequently ____
45. Do you have any leg cramps or pain your thighs or legs when walking? Rarely/Never____ Occasionally ___ Frequently ____
46. Are you bothered by leg cramps at night? Rarely/Never____ Occasionally ___ Frequently ____
47. Do you ever have to sit up at night to breathe easily? Rarely/Never____ Occasionally ___ Frequently ____
48. Do you use 2 pillows at night to help you breathe easier? Rarely/Never____ Occasionally ___ Frequently ____
49. Would say you are a restless sleeper? Rarely/Never____ Occasionally ___ Frequently ____
50. Do you sometimes have swollen ankles or feet? Rarely/Never____ Occasionally ___ Frequently ____
51. How often, If ever:
A. Are you nauseated? Rarely/Never____ Occasionally ___ Frequently ____
B. Do you have stomach pains? Rarely/Never____ Occasionally ___ Frequently ____
C. Do you burp a lot after eating? Rarely/Never____ Occasionally ___ Frequently ____
D. Do you have heartburn? Rarely/Never____ Occasionally ___ Frequently ____
E. Do you have trouble swallowing your food? Rarely/Never____ Occasionally ___ Frequently ____
F. Have you vomited blood? Rarely/Never____ Occasionally ___ Frequently ____
G. Are you constipated? Rarely/Never____ Occasionally ___ Frequently ____
H. Do you have diarrhea? Rarely/Never____ Occasionally ___ Frequently ____

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FAMILY	AGE(s)	ALIVE	DECEASED	HEALTH STATUS	CAUSE OF DEATH
FATHER					
MOTHER					
SISTER(s)					
BROTHER(s)					
CHILDREN					

	FATHER	MOTHER	FATHER'S PARENT	MOTHER'S PARENT	SIBLINGS	CHILDREN
• HEART DISEASE	____	_____	_____	____	____	____
• HIGH BLOOD PRESSURE	____	_____	_____	____	____	____
• STROKE	____	_____	_____	____	____	____
• CANCER	____	_____	_____	____	____	____
• GLAUCOMA	____	_____	_____	____	____	____
• DIABETES	____	_____	_____	____	____	____
• EPILEPSY/CONVULSION	____	_____	_____	____	____	____
• BLEEDING DISORDER	____	_____	_____	____	____	____
• KIDNEY DISEASE	____	_____	_____	____	____	____
• THYROID DISEASE	____	_____	_____	____	____	____
• MENTAL ILLNESS	____	_____	_____	____	____	____
• OSTEOPOROSIS	____	_____	_____	____	____	____

FOR DOCTOR'S COMMENT ONLY

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SOCIAL HISTORY

Date of Birth _____ Place of Birth _____ Years in California ____
Grew up in what city/ies

_____

Are you generally satisfied with your life? Yes ____ No____, If not please explain.

_____

_____

List any source/s of stress and strain that you are dealing with or dealt with in the recent past.

_____

_____

_____

Marital Status: Single ____ Married ___ How many times? ___ & Duration of marriage ___
Widow ____When? _____
Divorced ___How long? _____
Separated ___ How long? _____

In case of emergency, indicate name & telephone number of person to contact

_____

Educational History/Environmental History

Describe current home situations:

Who are you living with _____, number of member/s in the household _____
Is it apartment _____, House _____, upstairs _____, Downstairs _____
Years of school completed _____
Any recent travels/vacation _____
Any military service date/s and place of duty/ies _____
Any occupational toxic exposures, asbestos, etc _____

Activity History: Describe/List

Exercise program: _____
Hobbies: _____
Religious Preference _____
Any pet/s: _____

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DRUG/HABIT HISTORY:

Did you ever use tobacco? Yes ___ No ___ If yes, list all kinds_____
When started (age or year)? _____ How much daily? _____
When stopped (age or year)? _____
Have you restarted? No ____ Yes ___ If yes, when _____ How much daily now? _____

Did you ever drink alcoholic beverage? No ____ Yes ____ If yes, what kind _____
When started (age or year)? _____ How much daily? _____ How much weekly? _____
When stopped (age or year)? _____
If you still drink, how much do you consume now? Daily amount _____ Weekly amount _____

Have you ever used any street drugs? No ___ Yes ___ If yes, what kind _____
When started (age & year)? _____When stopped (age & year)? _____
Were you ever given treatment for use of street drugs? Yes ___ No ____
When? _____ Treatment received? _____

SEXUAL HISTORY

Do you have any concerns with sexual feelings and performance? No ___ Yes ___ If yes, please describe
_____
_____

MOOD/EMOTIONAL HISTORY:

Any history of suicide attempts? No ___ Yes ___ Any history of Depression? No ____ Yes ____
Describe you current mood _____
_____

NUTRITION & DIET

1. Are you on a special diet? No__ Yes__
2. How many meals do you eat each day? ____ meals each day
3. Do you usually eat for breakfast? No ___ Yes ___
4. Do you diet frequently and/or are now dieting? No __ Yes __
5. Do you consider yourself ___underweight ___overweight ___ just right
6. Do you snack? ___ More than once a day ___ Usually daily ___ Rarely
7. Do you add salt to your food at the table? __ Almost always ___Sometimes __ Never

	More than once daily	Daily	3 times weekly	Once weekly	Twice weekly	Less or Never
a. Whole grain or enriched bread or cereal						
b. Milk, cheese, or other dairy products						
c. Eggs						
d. Meat						
e. Citrus						
f. Dark green or deep yellow vegetables						

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Additional patient comments: _____

Thanks for completing this questionnaire. Please review for skipped questions, sign your name on the space to the right and return it to the physicians or assistant. If you wish to add any information, please write it on the space provided above.

Patient's Signature _____

Physician's Comments:

SUBJECTIVE: _____

Diagnosis/es:

1. _____
2. _____
3. _____
4. _____

Plan:

1. _____
2. _____
3. _____
4. _____

Return To Care _____ Signed _____