Patient Name: _____ Date of Birth: _____

	YES	If YES, please explain	M.D. Exam
Heartburn / indigestion	☐	_____	☐ WNL
Nervous stomach	☐	_____	☐ WNL
History of stomach ulcers	☐	_____	☐ WNL
Diarrhea	☐	_____	☐ WNL
Constipation	☐	_____	☐ WNL
History of colitis	☐	_____	☐ WNL
Irritable bowel	☐	_____	☐ WNL
Hemorrhoids	☐	_____	☐ WNL
Rectal bleeding	☐	_____	☐ WNL
Rectal pain	☐	_____	☐ WNL
Gallbladder trouble	☐	_____	☐ WNL
Hepatitis	☐	_____	☐ WNL
Liver problems	☐	_____	☐ WNL
Urology	☐	_____	☐ WNL
Trouble to urinate	☐	_____	☐ WNL
Trouble slopping urination	☐	_____	☐ WNL
Burning	☐	_____	☐ WNL
Frequent urination	☐	_____	☐ WNL
(Number of times/day _____)	☐	_____	☐ WNL
Night time urination	☐	_____	☐ WNL
Incontinence of urine with cough/sneezing	☐	_____	☐ WNL
Blood in urine	☐	_____	☐ WNL
Kidney stones	☐	_____	☐ WNL
Urinary tract infection	☐	_____	☐ WNL
Bruise easily	☐	_____	☐ WNL
Bleeding problems	☐	_____	☐ WNL
Varicose veins	☐	_____	☐ WNL
Phlebitis	☐	_____	☐ WNL
Muscle cramps	☐	_____	☐ WNL
Muscle aches arms/legs	☐	_____	☐ WNL
Dizziness	☐	_____	☐ WNL
Memory Loss	☐	_____	☐ WNL
Lightheadedness	☐	_____	☐ WNL
Feeling faint	☐	_____	☐ WNL
Seizures	☐	_____	☐ WNL
Numbness in hands/arms or legs/feet	☐	_____	☐ WNL
Weakness in arms/hands or legs/feet	☐	_____	☐ WNL
Joint pains or stiffness in:	☐	_____	☐ WNL
Fingers	☐	_____	☐ WNL
Wrists	☐	_____	☐ WNL
Elbows	☐	_____	☐ WNL
Shoulders	☐	_____	☐ WNL
Hips	☐	_____	☐ WNL
Knees	☐	_____	☐ WNL
Ankles	☐	_____	☐ WNL
Feet	☐	_____	☐ WNL
Neck pain	☐	_____	☐ WNL
Back pain	☐	_____	☐ WNL
Thyroid problems	☐	_____	☐ WNL
Thirsty	☐	_____	☐ WNL
Dry Skin	☐	_____	☐ WNL
Oily Skin	☐	_____	☐ WNL
Cold all the time	☐	_____	☐ WNL

Patient Name: _____ Date of Birth: _____

	YES	If YES, please explain	M.D. Exam
Diabetes (includes with pregnancy)	☐	_____	☐ WNL
Low Blood sugar	☐	_____	☐ WNL
High cholesterol	☐	_____	☐ WNL
Depression	☐	_____	☐ WNL
Sleeping problems	☐	_____	☐ WNL
Snoring	☐	_____	☐ WNL
Anxiety	☐	_____	☐ WNL
Nervous	☐	_____	☐ WNL
Irritable	☐	_____	☐ WNL
Anger problems	☐	_____	☐ WNL
DIET	☐	_____	☐ WNL
Fat intake: High Medium Low	☐	_____	☐ WNL
Salt intake: High Medium Low	☐	_____	☐ WNL
Present weight: _____ Weight at 20: _____	☐	_____	☐ WNL
Weight change last year:_____ lbs gained / lost	☐	_____	☐ WNL
Aerobic exercise frequency? _____	☐	_____	☐ WNL
How long each time? _____	☐	_____	☐ WNL
Do you use seatbelts?	☐	_____	☐ WNL
Do you use a bike helmet?	☐	_____	☐ WNL
FEMALES ONLY	☐	_____	☐ WNL
Breast lumps, nodules	☐	_____	☐ WNL
Breast milk discharge	☐	_____	☐ WNL
Breast biopsy	☐	_____	☐ WNL
Last mammogram: _____	☐	_____	☐ WNL
Last pap: _____	☐	_____	☐ WNL
History of abnormal pap	☐	_____	☐ WNL
History of genital warts	☐	_____	☐ WNL
History of genital herpes	☐	_____	☐ WNL
Vaginal discharge	☐	_____	☐ WNL
Vaginal itch or bad odor	☐	_____	☐ WNL
Vaginal Bleeding	☐	_____	☐ WNL
Abnormal periods	☐	_____	☐ WNL
Too short / Too long	☐	_____	☐ WNL
Increased frequency	☐	_____	☐ WNL
Short frequency	☐	_____	☐ WNL
Hot flashes	☐	_____	☐ WNL
Other	☐	_____	☐ WNL
STD history	☐	_____	☐ WNL
MALES ONLY	☐	_____	☐ WNL
Erection problems	☐	_____	☐ WNL
Sterility	☐	_____	☐ WNL
Premature ejaculation Impotence	☐	_____	☐ WNL
Difficulty urinating	☐	_____	☐ WNL
Discharge	☐	_____	☐ WNL
Other	☐	_____	☐ WNL
Genital warts, herpes	☐	_____	☐ WNL
Testicutar mass/lump	☐	_____	☐ WNL
Date of your last PSA: _____	☐	_____	☐ WNL
Fevers	☐	_____	☐ WNL
Chills	☐	_____	☐ WNL
Sweats (day or night)	☐	_____	☐ WNL
Weight loss / gain	☐	_____	☐ WNL
Fatigue	☐	_____	☐ WNL

Patient Name: _____ Date of Birth: _____

	YES	If YES, please explain	M.D. Exam
History of anemia	☐		☐ WNL
Weakness	☐		☐ WNL
Skin rash, lumps, nodules	☐		☐ WNL
Tumor or swelling	☐		☐ WNL
Headaches	☐		☐ WNL
Eye troubles	☐		☐ WNL
Ear troubles	☐		☐ WNL
Pain	☐		☐ WNL
Hearing Loss	☐		☐ WNL
Ringing	☐		☐ WNL
Imbalance / dizziness	☐		☐ WNL
Nose troubles - sinusitis	☐		☐ WNL
Bleeding	☐		☐ WNL
Stuffiness	☐		☐ WNL
Drainage	☐		☐ WNL
Hay fever	☐		☐ WNL
Throat troubles	☐		☐ WNL
Hoarseness	☐		☐ WNL
Pain	☐		☐ WNL
Lymph nodes / swelling	☐		☐ WNL
Lung troubles	☐		☐ WNL
Shortness of breath at rest	☐		☐ WNL
Shortness of breath with exercise	☐		☐ WNL
Sleep sitting up because short of breath	☐		☐ WNL
Awakens at night from shortness of breath	☐		☐ WNL
Wheezing	☐		☐ WNL
Asthma	☐		☐ WNL
Cough	☐		☐ WNL
Hx of recurring pneumonia	☐		☐ WNL
Hx of recurring bronchitis	☐		☐ WNL
Heart Troubles	☐		☐ WNL
Chest Pain	☐		☐ WNL
Skipping heart beats / palpitations	☐		☐ WNL
Irregular heart rhythm	☐		☐ WNL
Heart murmur	☐		☐ WNL
Heart Failure	☐		☐ WNL
Black out spells	☐		☐ WNL
Hypertension	☐		☐ WNL
Low blood pressure	☐		☐ WNL
Ankle swelling	☐		☐ WNL
GI Problems	☐		☐ WNL
Loss of appetite	☐		☐ WNL
Fills up quickly with eating	☐		☐ WNL
Pain with swallowing	☐		☐ WNL
Food catching with swallowing	☐		☐ WNL
Chest with drinking fizzy drinks	☐		☐ WNL
Abdominal pain	☐		☐ WNL
Nausea / Vomiting	☐		☐ WNL

EASTSIDE FAMILY HEALTH CENTER

Frank Marinkovich M.D. * Rita Marinkovich, ARNP
425-899-2525

Name: _____ Birthdate: _____ Date: _____

Family History

	Father	Mother	Grand-Parents	Siblings	Children
High Blood Pressure	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐
Breast Cancer	☐	☐	☐	☐	☐
Colon Cancer	☐	☐	☐	☐	☐
Other Cancer	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐

PAST MEDICAL HISTORY

SURGERIES / ACCIDENTS

1. _____
2. _____
3. _____

HOSPITALIZATIONS

1. _____
2. _____
3. _____

MEDICAL PROBLEMS PREVIOUSLY TREATED

1. _____
2. _____
3. _____

CURRENT MEDICAL COMPLAINTS

1. _____
2. _____
3. _____

ALLERGIES AND MEDICATION SENSITIVITIES

1. _____
2. _____
3. _____

CURRENT MEDICATIONS

1. _____
2. _____
3. _____

DRUGS FEQUENTLY OR PRESENTLY USED

☐SLEEPING PILL	☐CORTISONE	☐LAXATIVE
☐TRANQUILIZER	☐THYROID	☐ANTACIDS
☐ANTI-DEPRESSANT	☐HEART PILL	☐DECONGESTANT
☐DIET PILL	☐DIGITALIS	☐VITAMINS
☐DIABETIC PILL	☐NITROGLYCERIN	☐IRON
☐ESTROGEN HORMONE	☐WATER PILL / DIURETIC	☐ANTIBIOTCS
☐BIRTH CONTROL PILL	☐BLOOD PRESSURE PILL	☐ASTHMA PILL
☐INSULIN	☐"RECREATIONAL DRUGS"	☐OTHER

VACCINATIONS / INJECTIONS

	DATE		DATE
TETANUS	_____	HEP A	_____
PNEUMONIA	_____	HEP B	_____
MEASLES	_____	FLU	_____
HORMONE	_____	OTHER	_____

SOCIAL HISTORY

OCCUPATION: _____
MARITAL STATUS: S M W D

SMOKING
PACKS PER DAY _____
NO. OF YEARS _____
YEARS STOPPED _____
PIPE___ CIGAR ___ CHEW ___

ALCOHOL
(PLEASE CIRCLE ONE)
NEVER OCCASIONAL
HEAVY MODERATE
ALCOHOL PROBLEM? Y / N

COFFEE
CUPS PER DAY _____

ASPIRIN
TABS PER DAY _____