P. O. Box 476
Rutherford College, NC 28671

ALAN F. JACKS, M. D.

Phone: 828-874-0555

PATIENT NAME: ________________________ **DATE:** ______________ **CHART #** __________

MAIN PROBLEM(S) for which you came today: ____

YOUR PAST MEDICAL HISTORY: Have you ever had or been treated for:

Sugar Diabetes: no: _____ yes: _____ for how long? ________Insulin? yes _____ no _____
Heart Attack: no: _____ yes: _____ when? ____________________________________
Other heart trouble: no: _____ yes: _____ what kind? ________________________________
Stroke: no: _____ yes: _____ when? ____________________________________
High blood pressure: no: _____ yes: _____ for how long? ______________________________
Cancer: no: _____ yes: _____ what kind? __________________________________

Any other medical problems: ____
Women Only: How many pregnancies have you had? ______ How many babies born? ______
Last menstrual period: ___________ Are you using birth control? _____ Type: ________

YOUR PAST SURGICAL HISTORY:
What operations have you had and when?

____
____
____
____
____

ANY ALLERGIES:
Are you allergic to any medications or dye?

____
____
____
____
____

MEDICATIONS YOU ARE TAKING: Please list the current **medications** you are taking, their **dosages,** and **how often you take them** **(include over the counter meds):**

___________________ ___________________ ___________________
___________________ ___________________ ___________________
___________________ ___________________ ___________________
___________________ ___________________ ___________________
___________________ ___________________ ___________________

YOUR FAMILY'S MEDICAL HISTORY: Does or did anyone in your family **other than yourself** have:

Breast cancer yes ____ no ____ Inflammatory Bowel Disease yes ____ no ____
Colon cancer yes ____ no ____ Heart Attack yes ____ no ____
Stroke yes ____ no ____ Other cancers: ______________________________________
Other medical problems: ____

P. O. Box 476
Rutherford College, NC 28671

ALAN F. JACKS, M. D.

Phone: 828-874-0555

YOUR SOCIAL HISTORY:

Marital status: ______________ Number of children: ______ Occupation: ________________________

Do you **smoke** or use **tobacco**? _____ Have you ever? _____ **IF SO:** How many packs per day? ______,

And how many years? _______. If you have quit smoking, when did you? ________________

Do you drink **beer** or **alcohol**? none ______ small amount ______ moderate ______ large amount ______

SYSTEM REVIEW:

Constitutional Symptoms			**Gastrointestinal**			**Ear/Nose/Throat/Mouth**		
Fever	Yes	No	Abdominal Pain	Yes	No	Ear Infection	Yes	No
Chills	Yes	No	Change in appetite	Yes	No	Sore Throat	Yes	No
Weight Loss	Yes	No	Nausea and Vomiting	Yes	No	Sinus Problems	Yes	No
Yellow Jaundice	Yes	No	Constipation	Yes	No	**Respiratory**		
Eyes			Diarrhea	Yes	No	Wheezing	Yes	No
Blurred Vision	Yes	No	Blood in Stool	Yes	No	Frequent Cough	Yes	No
Neurological			**Cardiovascular**			Asthma	Yes	No
Sudden Weakness	Yes	No	Chest Pain	Yes	No	**Psychological**		
Extremity Paralysis	Yes	No	Shortness of Breath	Yes	No	Depression	Yes	No
Tremors/Shakes	Yes	No	Swelling of Feet	Yes	No	Excessive Anxiety	Yes	No
Dizzy Spells	Yes	No	**Skin**			Sleeplessness	Yes	No
Numbness/tingling	Yes	No	Skin Rashes	Yes	No	**List any other symptoms that bother you:**		
Endocrine			Boils	Yes	No			
Excessive Thirst	Yes	No	Wounds	Yes	No	____________________		
Too Hot/Too Cold	Yes	No	If yes, where? ______________					
Tired or Sluggish	Yes	No				____________________		
Musculoskeletal			____________________					
Joint Pain	Yes	No				____________________		
Neck Pain	Yes	No						
Back Pain	Yes	No	____________________			____________________		