

Patient's Name: \_\_\_\_\_ Chart # \_\_\_\_\_ Date: \_\_\_\_\_ Physician's # \_\_\_\_\_

**General Medical Information (Answering all questions will help us to be appraised of your general health status)**

Are you **ALLERGIC** TO ANY MEDICATIONS? \_\_\_ NO \_\_\_ YES Please list them: \_\_\_\_\_

Current medications: \_\_\_\_\_

**List all surgical procedures and any hospitalization in your lifetime:**

	Year	Year
_____	_____	_____
_____	_____	_____
_____	_____	_____

**Past Medical (Check the ones you have had)**

- |   |  |   |   |
|---|--|---|---|
| <input type="checkbox"/> Acid Reflux        | <input type="checkbox"/> Depression          | <input type="checkbox"/> Gout                     | <input type="checkbox"/> Sickle Cell Anemia |
| <input type="checkbox"/> Hiatal Hernia      | <input type="checkbox"/> Pulmonary embolism  | <input type="checkbox"/> Heart Attack             | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Hyperlipidemia      | <input type="checkbox"/> Heart Disease            | <input type="checkbox"/> Thyroid Problems   |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Panic Attacks       | <input type="checkbox"/> Hepatitis                | <input type="checkbox"/> Tuberculosis       |
| <input type="checkbox"/> Bleeding Disorder  | <input type="checkbox"/> Osteoporosis        | <input type="checkbox"/> High Blood Pressure      | <input type="checkbox"/> Ulcers             |
| <input type="checkbox"/> Blood Transfusion  | <input type="checkbox"/> Migraine headaches  | <input type="checkbox"/> HIV/AIDS                 | <input type="checkbox"/> Overactive bladder |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Anxiety             | <input type="checkbox"/> Kidney/Bladder Infection |   |
| <input type="checkbox"/> Chronic Bronchitis | <input type="checkbox"/> Epilepsy            | <input type="checkbox"/> Kidney Stones            |   |
| <input type="checkbox"/> Diabetes           | <input type="checkbox"/> Gallbladder Trouble | <input type="checkbox"/> Phlebitis                |   |

**Social History (Please check)**

Do you have children? \_\_\_ NO \_\_\_ YES # \_\_\_\_\_

Do you live alone? \_\_\_ NO \_\_\_ YES

Are you on a special diet? \_\_\_ NO \_\_\_ Describe: \_\_\_\_\_

Do you smoke currently? \_\_\_ NO \_\_\_ YES Amount \_\_\_\_\_ Pack(s) a day for \_\_\_\_\_ Years(s)

Have you quit smoking? \_\_\_ NO \_\_\_ YES Amount \_\_\_\_\_ Pack(s) a day for \_\_\_\_\_ Years(s)

How much alcohol, do you drink? \_\_\_ None \_\_\_ Occasional \_\_\_ 1-2 Drinks a day \_\_\_ More

**Work History: (Please Check)**

\_\_\_ Employed \_\_\_ Unemployed \_\_\_ Self-Employed \_\_\_ Student \_\_\_ Homemaker \_\_\_ Retired \_\_\_ Disabled

Company's Name: \_\_\_\_\_

Occupation/Work description: \_\_\_\_\_

**Family History: (Please check any that have occurred in Blood Relatives)**

- |  |                                       |  |  |   |                                 |
|--|---------------------------------------|--|--|---|---------------------------------|
| <input type="checkbox"/> Bleeding      | <input type="checkbox"/> Diabetes     | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Stroke          | <input type="checkbox"/> Arthritis      | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Sickle Cell Anemia  | <input type="checkbox"/> Nervous Illness | <input type="checkbox"/> Kidney Disease |                                 |

Do you have a regular family physician? \_\_\_ NO \_\_\_ YES

**Physician's Complete Information** Name \_\_\_\_\_

\_\_\_ **Please be complete** Street Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone number: ( \_\_\_\_\_ ) \_\_\_\_\_ -- \_\_\_\_\_

## REVIEW OF SYMPTOMS

Please check any of the following symptoms which apply to you. Use the space provided to describe any detailed history of these problems. Please cross out anything that does not apply.

### I. General Health

Present Weight: \_\_\_\_\_ Height: \_\_\_\_\_ BMI: \_\_\_\_\_

- \_\_\_ Any significant weight change? \_\_\_\_\_
- \_\_\_ Loss of appetite? \_\_\_\_\_
- \_\_\_ Recent fever? \_\_\_\_\_

### II. Eye, Ear, Nose & Throat

- \_\_\_ Recent bad cold or sinus infection? \_\_\_\_\_
- \_\_\_ Frequent hay fever symptoms? Seasonal / Year round? \_\_\_\_\_
- \_\_\_ Vision trouble? \_\_\_\_\_
- \_\_\_ Hearing trouble? \_\_\_\_\_
- \_\_\_ Frequent nose bleeds? \_\_\_\_\_

### III. Respiratory

- \_\_\_ Shortness of breath? \_\_\_\_\_
- \_\_\_ Frequent cough? \_\_\_\_\_
- \_\_\_ Wheezing? \_\_\_\_\_

### IV. Cardiac

- \_\_\_ Chest pains? \_\_\_\_\_
- \_\_\_ Heart murmur? \_\_\_\_\_
- \_\_\_ Palpitations/irregular heartbeat? \_\_\_\_\_
- \_\_\_ Dizziness/light headedness? \_\_\_\_\_

### V. Skin

- \_\_\_ Rash? \_\_\_\_\_
- \_\_\_ Psoriasis? \_\_\_\_\_
- \_\_\_ Eczema? \_\_\_\_\_

### VI. GI

- \_\_\_ Frequent heartburn or indigestion? \_\_\_\_\_
- \_\_\_ Frequent nausea or vomiting? \_\_\_\_\_
- \_\_\_ Constipation? \_\_\_\_\_ Diarrhea? \_\_\_\_\_
- \_\_\_ Blood in stools or black stools? \_\_\_\_\_

### VII. Urinary

- \_\_\_ Painful urination? \_\_\_\_\_
- \_\_\_ Blood in urine or dark urine? \_\_\_\_\_
- \_\_\_ Loss of bladder control? \_\_\_\_\_

### VIII. Neurological

- \_\_\_ Frequent headaches? \_\_\_\_\_
- \_\_\_ Loss of balance? \_\_\_\_\_
- \_\_\_ Seizures? \_\_\_\_\_
- \_\_\_ Fainting spells? \_\_\_\_\_
- \_\_\_ Have you been diagnosed with fibromyalgia, RSD or pain syndrome? \_\_\_\_\_

### IX. Hematological

- \_\_\_ Easy bruising and bleeding? \_\_\_\_\_
- \_\_\_ Sever blood loss with previous surgery? \_\_\_\_\_