

Patient Name: _____ Date: _____

Are you allergic to any medications? NO YES Please list: _____

Past Medical History				Current Medications				
	Yes	No	Yes	No	Yes	No		
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	Osteoporosis	<input type="checkbox"/>	<input type="checkbox"/>	Blood Clots	<input type="checkbox"/>	<input type="checkbox"/>
Chest Pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Asthma/COPD	<input type="checkbox"/>	<input type="checkbox"/>	Peripheral Vascular Disease	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Stroke/CVA/TIA	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>
Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	HIV/AIDS	<input type="checkbox"/>	<input type="checkbox"/>	Congestive Heart Failure	<input type="checkbox"/>	<input type="checkbox"/>
High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Disease	<input type="checkbox"/>	<input type="checkbox"/>
Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Ulcer	<input type="checkbox"/>	<input type="checkbox"/>	<u>Other (please list below)</u>		
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney Stones	<input type="checkbox"/>	<input type="checkbox"/>	Heart Palpitations	<input type="checkbox"/>	<input type="checkbox"/>			
Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>			
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Heart Surgery	<input type="checkbox"/>	<input type="checkbox"/>			

ROS	(-)	Please check all CURRENT positive findings
Constitutional		Weight loss <input type="checkbox"/> Fevers <input type="checkbox"/> Chills <input type="checkbox"/> Poor appetite <input type="checkbox"/> Fatigue <input type="checkbox"/> Weight gain <input type="checkbox"/> Insomnia <input type="checkbox"/> Night sweats <input type="checkbox"/>
Eyes		Blurry vision <input type="checkbox"/> Eye pain <input type="checkbox"/> Eye discharge <input type="checkbox"/> Eye redness <input type="checkbox"/> Decrease in vision <input type="checkbox"/> Dry eyes <input type="checkbox"/> Double vision <input type="checkbox"/>
ENT		Sore throat <input type="checkbox"/> Hoarseness <input type="checkbox"/> Ear pain <input type="checkbox"/> Hearing loss <input type="checkbox"/> Ear discharge <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Tinnitus <input type="checkbox"/> Sinus problems <input type="checkbox"/>
Cardiovascular		Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Rapid heart rate <input type="checkbox"/> Heart murmur <input type="checkbox"/> Poor circulation <input type="checkbox"/> Swelling in the legs or feet <input type="checkbox"/>
Respiratory		Shortness of breath <input type="checkbox"/> Chronic cough <input type="checkbox"/> Coughing up blood <input type="checkbox"/> History of Tuberculosis <input type="checkbox"/> Excess sputum production <input type="checkbox"/>
Gastrointestinal		Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in the stool <input type="checkbox"/> Frequent heartburn <input type="checkbox"/> Trouble swallowing <input type="checkbox"/>
Genitourinary		Increased urinary frequency <input type="checkbox"/> Blood in the urine <input type="checkbox"/> Incontinence <input type="checkbox"/> Painful urination <input type="checkbox"/> Urinary retention <input type="checkbox"/> Frequent UTIs <input type="checkbox"/>
Skin		Rash <input type="checkbox"/> Hives <input type="checkbox"/> Hair loss <input type="checkbox"/> Skin sores or ulcers <input type="checkbox"/> Itching <input type="checkbox"/> Skin thickening <input type="checkbox"/> Nail changes <input type="checkbox"/> Mole changes <input type="checkbox"/>
Musculoskeletal		Joint pain <input type="checkbox"/> Muscle aches <input type="checkbox"/> Frequent leg cramps <input type="checkbox"/> Muscle weakness <input type="checkbox"/> Bone pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Back pain <input type="checkbox"/>
Psychiatric		Anxiety <input type="checkbox"/> Depression <input type="checkbox"/> Alcohol or drug dependence <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Panic attacks <input type="checkbox"/> Use of anti-depressants <input type="checkbox"/>
Endocrine		Goiter <input type="checkbox"/> Heat intolerance <input type="checkbox"/> Cold intolerance <input type="checkbox"/> Increased thirst <input type="checkbox"/> Change in skin pigment <input type="checkbox"/> Excess sweating <input type="checkbox"/>
Neurological		Seizures <input type="checkbox"/> Tremors <input type="checkbox"/> Migraines <input type="checkbox"/> Numbness <input type="checkbox"/> Dizziness/Vertigo <input type="checkbox"/> Loss of balance <input type="checkbox"/> Slurred speech <input type="checkbox"/> Stroke <input type="checkbox"/>
Hem/Lymphatic		Low blood count <input type="checkbox"/> Easy bruising <input type="checkbox"/> Swollen lymph nodes <input type="checkbox"/> Transfusions <input type="checkbox"/> Prolonged bleeding <input type="checkbox"/> Blood clots <input type="checkbox"/>
Allergic/Immun		Allergic reactions <input type="checkbox"/> Hay fever <input type="checkbox"/> Frequent infections <input type="checkbox"/> Hepatitis <input type="checkbox"/> HIV positive <input type="checkbox"/> Positive tuberculin skin test (PPD) <input type="checkbox"/>

Social History: Marital Status _____ Occupation (or most recent job held) _____
 Non-Smoker (never smoked) Ex-Smoker Current Smoker How many packs per day? _____
 Alcohol consumption: Never Occasional Frequent

Family History: (Please list any known medical problems)
 Father: _____ Mother: _____
 Siblings: _____
 Your Children: _____

Additional Information: Use this space to provide any additional information which may be important to your health care.

Signature of Reviewing Physician _____ Date _____ Signature of Patient _____ Date _____