Name _____ **Birth Date** _____ **Todays Date** _____

Occupation _____ PCP _____

REASON/NATURE OF VISIT Use the space below to describe the reason for your visit and any special concerns.

REVIEW OF SYSTEMS/PAST MEDICAL HISTORY Please check any that you have ***ever*** had. ☐ **NONE**

Constitutional
- ☐ Fatigue
- ☐ Sleep Difficulty
- ☐ Weight Gain
- ☐ Chronic Pain
- ☐ Weight Loss

Head/Nose/Ears/Mouth
- ☐ Dizziness
- ☐ Fainting
- ☐ Headache
- ☐ Migraine
- ☐ Nose Bleeds
- ☐ Sinus Problems
- ☐ Difficulty Swallowing
- ☐ Hearing Aid
- ☐ Ringing of Ears
- ☐ Hearing Loss
- ☐ Hoarseness
- ☐ Sore Throat

Respiratory
- ☐ Asthma
- ☐ Emphysema
- ☐ Pneumonia
- ☐ Exposure to Tuberculosis
- ☐ COPD
- ☐ Difficulty Breathing
- ☐ Short of Breath

Cardiovascular
- ☐ Congestive Heart Failure
- ☐ Fast Heart Beat
- ☐ Heart Attack
- ☐ Stents
- ☐ Atrial Fibrillation
- ☐ Cramps in Legs/Feet
- ☐ Heart Murmur
- ☐ High Cholesterol
- ☐ Palpations
- ☐ Chest Pain
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Varicose Veins
- ☐ Coronary Artery Disease
- ☐ Stroke
- ☐ Pacemaker

Gastrointestinal
- ☐ Diarrhea
- ☐ GERD
- ☐ Acid Reflux
- ☐ Colon Cancer
- ☐ Heart Burn
- ☐ Liver Disease
- ☐ Nausea
- ☐ Stomach Ulcers

Musculoskeletal
- ☐ Back Problems
- ☐ Joint Stiffness/Swelling
- ☐ Neuroma
- ☐ Weakness
- ☐ Joint Implants
- ☐ Arthritis
- ☐ Gout
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Limited Motion

Psychiatric
- ☐ Depression
- ☐ Anxiety
- ☐ Panic Attacks

Skin
- ☐ Abnormal Growth
- ☐ Hives
- ☐ Keloid Scar
- ☐ Psoriasis
- ☐ Warts
- ☐ Eczema
- ☐ Rash
- ☐ Skin Cancer
- ☐ Leg or Foot Ulcers
- ☐ Non-healing lesions

Allergic/Immunologic
- ☐ Hay Fever
- ☐ Hives
- ☐ Latex Sensitivity
- ☐ Metal Sensitivity

Neurological
- ☐ Alzheimer's
- ☐ Epilepsy
- ☐ Tingling
- ☐ Weakness
- ☐ Multiple Sclerosis
- ☐ Neuropathy
- ☐ Muscle Spasms
- ☐ Numbness

Endocrine
- ☐ Fatigue
- ☐ Sweats
- ☐ Diabetes
- ☐ Thirst
- ☐ Prostate Problems
- ☐ Thyroid Problems
- ☐ Heat or Cold Intolerance

Hematologic/Lymph
- ☐ Anemia
- ☐ Bruise Easily
- ☐ History of Transfusion
- ☐ Slow Healing Cuts
- ☐ Hepatitis Type_____
- ☐ Blood Clots
- ☐ Recent Chemotherapy
- ☐ History of DVT
- ☐ HIV

Urinary
- ☐ Bladder Problems
- ☐ Excessive Urination
- ☐ Kidney Disease
- ☐ Burning with Urination

Eyes
- ☐ Eyeglasses
- ☐ Blurred Vision
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Dry Eyes

Other
- ☐ Cancer _____
- ☐ _____
- ☐ _____
- ☐ _____

Name_____ **Birth Date** _____ **Todays Date** _____

MEDICATION ALLERGIES List the medications that have caused bad reactions. Include your reaction (hives, rash, itching, nausea, etc).

☐ **NO KNOWN DRUG ALLERGIES** ☐ **LATEX ALLERGY** ☐ **METAL ALLERGY**

Medication Name	Type of Reaction	Medication Name	Type of Reaction
1.		3.	
2.		4.	

MEDICATIONS List the medications that you are taking (prescription, over-the-counter & supplements). Attach additional sheet if needed.

☐ **NONE**

Medication / Dose	How often per day?	Medication / Dose	How often per day?
1.		4.	
2.		5.	
3.		6.	

PHARMACY INFORMATION

Pharmacy Name & Location _____ Phone _____

FAMILY HISTORY ☐ **NONE** ☐ **ADOPTED** ☐ **UNKNOWN**

Please state if your relatives have had any of the following: Cancer, Heart Problems, Kidney Disease, Stroke, Arthritis, Diabetes, High Blood Pressure, Tuberculosis, Emphysema.

Relative	**Health Problem(s)**	**Age (if living)**	**Age (if deceased)**	**Cause of Death**
Mother				
Father				
Brother				
Sister				

SOCIAL HISTORY

Do you smoke? ☐ Yes ☐ No If yes, packs per day? _____ How long? _____
Did you smoke previously? ☐ Yes ☐ No If yes, what year did you quit? _____
Do you chew tobacco? ☐ Yes ☐ No If yes, how long? _____
Do you use any other products that contain nicotine? ☐ Yes ☐ No If yes, type_____
Alcohol use? ☐ Yes ☐ No If yes, how many drinks per week? _____

Height_____ **Weight**_____ **Shoe Size**_____

PREVIOUS PROCEDURES/SURGERIES ☐ **NONE** ☐ Pacemaker	**YEAR**
1.	
2.	
3.	
4.	
5.	

*****FOR OFFICE USE ONLY***** Reviewed with Patient Date: _____ Staff Initials: _____