Patient Name: _____ **DOB:** _____

CURRENT MEDICAL INFORMATON

Who is your primary care physician _____ **Did they refer you here today?** **Y or N**

Where do you go to have lab work done? _____

What is the medical problem for your visit today? _____

Height: _____ **Weight:** _____

Pain Scale from 1 to 10, (10 being the worst?) _____ **Age:** _____

MEDICATIONS

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

What pharmacy do you use to fill your prescriptions? _____

ALLERGIES

Please list any allergies you have and the adverse reaction.

Allergic to:	**Physical Response:**
1. _____	_____
2. _____	_____
3. _____	_____

SOCIAL HISTORY

What is your smoking status? Currently Every Day Currently Some days
Formerly Smoked Never Smoked

Tobacco years of use? _____

What is your alcohol intake? Occasional Moderate Heavy

Auto Accident Injury? _____ **Do you take any illicit drugs?** _____

What is your marital status? _____

How much do you smoke?

¼ pack per day?	¼ pack per week?
½ pack per day?	½ pack per week?
1 pack per day?	1 pack per week?
2 packs per day?	2 packs per week?
3 packs or more per day?	

Smoked since age? _____ **How many years of alcohol use?** _____

Work Related Injury? _____ **Are you employed?** _____

Patient Name: _____ DOB: _____

PAST MEDICAL HISTORY

Have you experienced any of the following symptoms in the PAST?

Y or N	**Anemia**	Y or N	**Asthma or Wheezing**
Y or N	**Bad Headaches**	Y or N	**Cancer**
Y or N	**Cataracts**	Y or N	**Colitis**
Y or N	**Coronary Artery Disease**	Y or N	**Depression/Psychiatric Problems**
Y or N	**Diabetes**	Y or N	**Emphysema**
Y or N	**Epilepsy**	Y or N	**Fracture**
Y or N	**Glaucoma**	Y or N	**Goiter**
Y or N	**HIV/AIDS**	Y or N	**Heart Disease**
Y or N	**Heart Problems**	Y or N	**Hypertension/High Blood Pressure**
Y or N	**Jaundice**	Y or N	**Kidney Disease**
Y or N	**Leukemia**	Y of N	**Muscle Spasm**
Y or N	**Nervous Breakdown**	Y or N	**Pneumonia**
Y or N	**Psoriasis**	Y or N	**Rash/Skin Ulcers**
Y or N	**Recurrent Infection**	Y or N	**Rheumatic Fever**
Y or N	**Sinusitis**	Y or N	**Stomach Ulcers**
Y or N	**Stroke**	Y or N	**Tuberculosis**

FAMILY HISTORY OF MEDICAL PROBLEMS

Please list any past family history of specific medical problems/diseases

Mother: _____ **Deceased:** _____

Father: _____ **Deceased:** _____

Sister: _____ **Deceased:** _____

Brother: _____ **Deceased:** _____

Additional: _____ **Deceased:** _____

Additional: _____ **Deceased:** _____

PAST SURGERY HISTORY

Please list all past surgery history within the last 10 years, beginning with most recent.

	Surgical Procedure	**Date of Surgery**
1.	_____	**Date:** _____
2.	_____	**Date:** _____
3.	_____	**Date:** _____
4.	_____	**Date:** _____
5.	_____	**Date:** _____

Patient Name: _____ **DOB:**_____

REVIEW OF SYSTEMS

Are you currently experiencing any of the following symptoms?

Y or N **Fever**
Y or N **Weight Gain _____ (lbs.)**
Y or N **Exercise Intolerance**

Y or N **Night Sweats**
Y or N **Weight Loss_____ (lbs.)**

Y or N **Dry Eyes**
Y or N **Vision Changes**

Y or N **Eye Irritation**

Y or N **Difficulty hearing**
Y or N **Frequent Nosebleeds**

Y or N **Ear Pain**
Y or N **Nose/Sinus Problems**

Y or N **Sore Throat**
Y or N **Dry Mouth**
Y or N **Oral Abnormalities**
Y or N **Mouth Breathing**

Y or N **Snoring**
Y or N **Ulcers**
Y or N **Teeth Problems/Abnormalities**

Y or N **Pleuritic Chest Pain**
Y or N **Shortness of Breath Lying Down**
Y or N **Light Headed on Standing**
Y or N **Cough**
Y or N **Shortness of Breath**

Y or N **Shortness of breath when walking**
Y or N **Raynaud's Phenomenon**

Y or N **Wheezing**
Y or N **Sleep Apnea**

Y or N **Abdominal Pain**
Y or N **Dysphagia**
Y or N **Normal Appetite**
Y or N **Black or Tarry Stools**

Y or N **Constipation**
Y or N **Vomiting**
Y or N **Diarrhea**

Y or N **Painful Urination**

Y or N **Muscle Aches**
Y or N **Arthralgia/Joint Pain**
Y or N **Swelling of the Extremities**
Y or N **Inflammation of fingers/toes**

Y or N **Muscle Weakness**
Y or N **Back Pain**
Y or N **Morning Stiffness**

Y or N **Skin Rashes**
Y or N **Growths or Lesions**
Y or N **Tightening of the Skin**
Y or N **Itching**

Y or N **Skin Ulcers**
Y or N **Hair Loss**
Y or N **Psoriasis**

Y or N **Nerve Weakness**
Y or N **Dizziness**
Y or N **Tingling/Pricking (pins & needles)**

Y or N **Nerve Numbness**
Y or N **Headaches**

Y or N **Depression**
Y or N **Fatigue**
Y or N **Easy Bruising**
Y or N **Hives**

Y or N **Sleep Disturbance**
Y or N **Increased Thirst**
Y or N **Excessive Bleeding**