

Name _____ Today's Date _____

Age _____ Birth date _____ Date of last physical exam _____

MEDICATIONS: List medications you are currently taking including aspirin, ibuprofen, over the counter medication, vitamins, eye drops ...

DRUGS	DOSE	DRUGS	DOSE
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

ALLERGIES: List all drug allergies.

DRUGS	TYPE OF REACTION	DRUGS	TYPE OF REACTION
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

SURGERIES: List all previous surgeries/procedures.

TYPE	APPROXIMATE DATE	TYPE	APPROXIMATE DATE
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

SERIOUS ILLNESS: Such as heart attack, stroke, diabetes, etc.

TYPE	APPROXIMATE DATE	TYPE	APPROXIMATE DATE
1. _____	_____	4. _____	_____
2. _____	_____	5. _____	_____
3. _____	_____	6. _____	_____

FAMILY HISTORY: Fill in health information about your family.

	YES	NO	RELATIONSHIP		YES	NO	RELATIONSHIP
Bleeding Tendency	<input type="checkbox"/>	<input type="checkbox"/>	_____	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Cholesterol	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer - Other	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Type _____							

HEALTH HABITS: Check (x) which substances you use and describe how much you use.

Caffeine (Coffee, Tea, etc.) _____ Tobacco _____

Alcoholic Beverages (Beer, Wine, Cocktails, etc.) _____

SYMPTOMS: Check (x) all symptoms you currently have or have had in the past year.

GENERAL

- Chills
- Fever
- Hot flashes
- Loss of weight
- Night sweats

EYES

- Blurred vision
- Double vision

NOSE, EARS, THROAT

- Difficulty swallowing
- Ringing in ears
- Sore throat

CARDIOVASCULAR

- Chest pain
- Irregular heartbeat
- Poor circulation
- Rapid heartbeat
- Swelling of ankles

Other _____

RESPIRATORY

- Chronic / Frequent cough
- Shortness of breath
- Spitting phlegm / blood

GASTROINTESTINAL

- Constipation
- Diarrhea
- Heartburn
- Nausea
- Rectal bleeding
- Tarry stools

GENITO-URINARY

- Blood in urine
- Frequent urination
- Lack of bladder control
- Kidney stones

MUSCLE & JOINTS

- Back aches
- Joint pain / Stiffness
- Leg cramps
- Swollen joints

SKIN / BREAST

- Breast lump
- Discharge from breast
- Rash
- Sore that won't heal

NEUROLOGICAL

- Headache
- Weakness

PSYCHOLOGICAL

- Depression

ENDOCRINE

- Excessive sweating
- Thirst
- Weight gain

ALLERGIC

- Itching
- Hives / Rash
- Wheezing

HEMATOLOGICAL LYMPHATIC

- Ankle swelling
- Bruise easily
- Nosebleed

CONDITIONS: Check (x) conditions you currently have or have had in the past year.

	YES	NO		YES	NO		YES	NO
Artificial valves	<input type="checkbox"/>	<input type="checkbox"/>	Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	Multiple sclerosis	<input type="checkbox"/>	<input type="checkbox"/>
Artificial joints	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>	Pacemaker	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Glaucoma	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problem	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	Hearth disease	<input type="checkbox"/>	<input type="checkbox"/>	Radiation treatment	<input type="checkbox"/>	<input type="checkbox"/>
Hemophilia	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	Sickle cell anemia	<input type="checkbox"/>	<input type="checkbox"/>
Chemotherapy	<input type="checkbox"/>	<input type="checkbox"/>	Herpes	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>
Congenital heart defect	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>
Mitral valve prolapse	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any member of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

Signature _____ Date _____

I have reviewed the above information and made any changes that have occurred since my last visit here.

Initials-Date _____ Initials/Date _____ Initials/Date _____

MD Signature _____ Date _____