Patient's Name: ______________________________ Date: ________________________

Purpose of Visit: ____
Other concerns you would like to discuss: ______________________________________

Have you had any of the following recently:
X-ray: ☐ Yes ☐ No Date it was preformed: ________ where was it done at? ______________________
Lab work: ☐ Yes ☐ No Date it was preformed: _____ where was it done at? ______________________
Ultrasound: ☐ Yes ☐ No Date it was preformed: ______ where was it done at? ____________________
MRI: ☐ Yes ☐ No Date it was preformed: ________ where was it done at? ______________________
CT Scans: ☐ Yes ☐ No Date it was preformed: __________ where was it done at? __________________

List all Past and Current Medical Condition:
Current: ____

____

Past: ____

____

List all Surgeries or Procedures, and the year:

Surgery/Procedure	Year	Facility

Current Medications (please list over-the-counter medications) including Herbal Supplements and Multi Vitamins.

Medication	Dose	Frequency	Medication	Dose	Frequency

Are you taking Aspirin, Ibuprofen, Coumadin, Beta Blockers, or any Blood thinners? ☐ Yes ☐ No Please List _____

____

Allergies to Medications: ☐ Yes ☐ No if yes, please explain ___________________________

____

Do you smoke: ☐ Yes ☐ No How many pack a day _____ for ______ years. Year you quit? _______________
Do you drink alcohol: ☐ Yes ☐ No How many drinks per day/week (circle one) ________________
Do you use any illicit drugs ☐ Yes ☐ No If yes, please explain __________________________

List any medical illnesses that run in your family: ______________________________________

____

If under 18 years old: Grade in school: _______ Are your immunizations up to date? ☐ Yes ☐ No

Patient's Name: ______________________ Date: ______________________

Review of Symptoms: Have you been treated by a physician for any of the following? Please answer **ALL** questions.
Check "Y" for Yes and "N" for No.

General:
- ☐ Y ☐ N Weight Gain
- ☐ Y ☐ N Weight Loss
- ☐ Y ☐ N Chills
- ☐ Y ☐ N Fatigue
- ☐ Y ☐ N Fevers

Skin:
- ☐ Y ☐ N Bruising
- ☐ Y ☐ N Changes in wart/mole
- ☐ Y ☐ N Excessive Sweating
- ☐ Y ☐ N New Lesions
- ☐ Y ☐ N Skin Color Changes

Eyes/Ears/Nose/Throat/Mouth:
- ☐ Y ☐ N Blurred Vision
- ☐ Y ☐ N Headache
- ☐ Y ☐ N Head Injury
- ☐ Y ☐ N Double Vision
- ☐ Y ☐ N Eye Pain
- ☐ Y ☐ N Hearing Loss
- ☐ Y ☐ N Deafness
- ☐ Y ☐ N Spinning Sensation
- ☐ Y ☐ N Nose Bleed
- ☐ Y ☐ N Frequent Colds
- ☐ Y ☐ N Nasal Congestion
- ☐ Y ☐ N Seasonal Allergies
- ☐ Y ☐ N Hoarseness
- ☐ Y ☐ N Sore Throat

Neck:
- ☐ Y ☐ N Neck Mass
- ☐ Y ☐ N Neck Pain
- ☐ Y ☐ N Neck Stiffness
- ☐ Y ☐ N Swollen Glands

Respiratory:
- ☐ Y ☐ N Chronic Cough
- ☐ Y ☐ N Snoring
- ☐ Y ☐ N Difficulty Breathing
- ☐ Y ☐ N Wheezing

Cardiovascular:
- ☐ Y ☐ N Fainting
- ☐ Y ☐ N Chest Pain
- ☐ Y ☐ N Calf Cramps
- ☐ Y ☐ N Irregular Heart Beat
- ☐ Y ☐ N Difficulty Breathing Lying Down

Cardiovascular (con't)
- ☐ Y ☐ N Elevated Blood Pressure
- ☐ Y ☐ N Palpitations
- ☐ Y ☐ N Rapid Heart Rate
- ☐ Y ☐ N Leg Pain/Swelling
- ☐ Y ☐ N Heart Attack

Date of occurrence ______________
- ☐ Y ☐ N Varicose Veins

*Are you taking Aspirin for any of the above?*______

Gastrointestinal:
- ☐ Y ☐ N Bloating
- ☐ Y ☐ N Hemorrhoids
- ☐ Y ☐ N Abdominal Mass
- ☐ Y ☐ N Abdominal Pain
- ☐ Y ☐ N Black, Tarry Stool
- ☐ Y ☐ N Bloody Stool
- ☐ Y ☐ N Constipation
- ☐ Y ☐ N Heartburn
- ☐ Y ☐ N Nausea
- ☐ Y ☐ N Rectal Bleeding
- ☐ Y ☐ N Vomiting

Musculoskeletal:
- ☐ Y ☐ N Leg Cramps
- ☐ Y ☐ N Back Ache
- ☐ Y ☐ N Joint Pain
- ☐ Y ☐ N Joint Swelling
- ☐ Y ☐ N Muscle Cramps
- ☐ Y ☐ N Muscle Weakness
- ☐ Y ☐ N Swelling to Extremities

Neurological:
- ☐ Y ☐ N Numbness
- ☐ Y ☐ N Decreased Memory
- ☐ Y ☐ N Difficulty Speaking
- ☐ Y ☐ N Headaches
- ☐ Y ☐ N Seizures
- ☐ Y ☐ N Visual Changes
- ☐ Y ☐ N Weakness
- ☐ Y ☐ N Stroke

Psychiatric:
- ☐ Y ☐ N Anxiety
- ☐ Y ☐ N Depression
- ☐ Y ☐ N Hallucinations
- ☐ Y ☐ N Insomnia
- ☐ Y ☐ N Panic Attacks

Endocrine:
- ☐ Y ☐ N Appetite Changes
- ☐ Y ☐ N Excessive Thirst
- ☐ Y ☐ N Heat Intolerance
- ☐ Y ☐ N Thyroid Problem
- ☐ Y ☐ N Excessive Urination

Hematology:
- ☐ Y ☐ N Excessive Bleeding
- ☐ Y ☐ N Anemia
- ☐ Y ☐ N Blood Clot
- ☐ Y ☐ N Easy Bruising
- ☐ Y ☐ N Enlarged Lymph Nodes
- ☐ Y ☐ N Spontaneous Bleeding

Immunologic:
- ☐ Y ☐ N HIV/AIDS
- ☐ Y ☐ N Hepatitis (A,B,or C)

Men Only:
- ☐ Y ☐ N Prostate Disease
- ☐ Y ☐ N Testicular Lump/Pain
- ☐ Y ☐ N Venereal Disease

Women Only:

Last Menstrual Period Started: _______
Number of Pregnancies: ___________
Number of Deliveries: ___________
Last Pap Smear (date): ___________
- ☐ Y ☐ N Menstrual Irregularities
- ☐ Y ☐ N Menopause, age? _________
- ☐ Y ☐ N Vaginal Discharge
- ☐ Y ☐ N Venereal Disease

Breast:

Last Mammogram date ___________
- ☐ Y ☐ N Breast Mass/Lump
- ☐ Y ☐ N Breast Pain
- ☐ Y ☐ N Nipple Discharge
- ☐ Y ☐ N Monthly Self Exam

FOR OFFICE USE ONLY
Weight:
Height:
Temperature:
Pulse
Respiration:
O2:
Blood Pressure: