Patient Name: Date:

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

Past Medical History

	Yes	No		Yes	No		Yes	No
Diabetes	☐	☐	Osteoporosis	☐	☐	Blood Clots	☐	☐
Chest Pain/Angina	☐	☐	Asthma/COPD	☐	☐	Peripheral Vascular Disease	☐	☐
High Blood Pressure	☐	☐	Stroke/CVA/TIA	☐	☐	Tuberculosis	☐	☐
Heart Disease	☐	☐	Seizures	☐	☐	Depression	☐	☐
Heart Attack	☐	☐	HIV/AIDS	☐	☐	Congestive Heart Failure	☐	☐
High Cholesterol	☐	☐	Hepatitis	☐	☐	Thyroid Disease	☐	☐
Pacemaker	☐	☐	Stomach Ulcer	☐	☐	Other (please list below)		
Headaches	☐	☐	Liver Disease	☐	☐			
Kidney Stones	☐	☐	Heart Palpitations	☐	☐			
Kidney Disease	☐	☐	Arthritis	☐	☐			
Cancer	☐	☐	Heart Surgery	☐	☐			

Current Medications

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

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