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 Problem ☐
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 (never smoked) ☐ 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