Medical History

Name: _____ DOB:_____ Date: _____

Review of Systems
(Please check all that apply)

EYES	
☐	Light Sensitivity
☐	Tenderness
☐	Visual Disturbance
EARS/NOSE/THROAT	
☐	Hearing Change
☐	Ringing in Ears
☐	Trouble Breathing
☐	Mouth Pain
☐	Difficulty Swallowing
CARDIOVASCULAR	
☐	Congestive Heart Failure
☐	Chest Pain
☐	Faintness
☐	Irregular Heartbeat
RESPIRATORY	
☐	Difficulty Breathing
☐	Congestion
☐	Dyspnea
☐	Wheezing
GASTROINTESTINAL	
☐	Constipation
☐	Diarrhea
☐	GERD
☐	Nausea
☐	Urinary Incontinence
☐	Vomiting
MUSCULOSKELETAL	
☐	Arthritis
☐	Leg Cramps
☐	Muscle Spasm
☐	Stiffness
INTEGUMENTARY	
☐	Skin Changes
☐	Abrasions
☐	Itchy Skin
☐	Lacerations
☐	Cuts
NEUROLOGICAL	
☐	Dizziness
☐	Fainting
☐	Numbness
☐	Paralysis
☐	Weakness
ENDOCRINE	
☐	Change in Appetite
☐	Kidney Disease
☐	Night Sweats
☐	Excessive Urination
HEMATOLOGIC	
☐	Long term anticoagulant use
☐	Bleeding /Clotting Disorders
☐	Sickle Cell Anemia

Past Medical History
(Please check all that apply)

☐	Diabetes
☐	Glaucoma
☐	Stroke / TIA
☐	Heart Attack / MI
☐	Artial Fibrillation
☐	High Cholesterol
☐	High Blood Pressure
☐	Seizure Disorder
☐	Kidney Disease
☐	Kidney Stones
☐	Prostate Problems
☐	Liver Disease / Hepatitis
☐	Asthma
☐	Gout
☐	Raynaud's
☐	Ulcerative Colitis
☐	Crohn's Disease
☐	Osteoarthritis
☐	Rheumatoid Arthritis
☐	Back / Spine Problems
☐	Fibromyalgia
☐	Anemia
☐	HIV / AIDS
☐	Cancer – Type:
☐	Anxiety
☐	Depression
☐	Alcohol Abuse
☐	Drug Abuse
☐	Thyroid Disorder
☐	Reflux / GERD
☐	Lyme Disease
☐	Osteopenia / Osteoporosis
☐	Other Medical Problems:

Have You Used Elicit Drugs? YES - NO

Do You Ever Drink Alcohol? YES - NO

Have You Used Tobacco? YES- NO- QUIT

Please list all previous surgeries and hospitalizations

Allergies / Reactions

☐	Penicillin
☐	Sulfa
☐	Latex
☐	Iodine / Shellfish
☐	Tape
☐	Local Anesthesia
☐	None
☐	Other:

Referred by: _____

Occupation: _____

☐ Married	☐ Single	☐ Partnered
☐ Widowed	☐ Divorced	

List or attach a complete list of all current **medications**:

Are there any diseases / illnesses that seem common or run in the family? _____

To the best of my knowledge, I have answered the questions on this as accurately as possible. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the doctor and the staff of any changes in my medical status.

_____

Print Name of Patient Signature of Patient/Parent/Guardian Date

_____

Doctor Signature Date