

Medical History

Name: _____ DOB: _____ Date: _____

Review of Systems
(Please check all that applies)

EYES
<input type="checkbox"/> Light Sensitivity
<input type="checkbox"/> Tenderness
<input type="checkbox"/> Visual disturbance
EARS/NOSE/THROAT
<input type="checkbox"/> Hearing Change
<input type="checkbox"/> Ringing in Ears
<input type="checkbox"/> Trouble breathing
<input type="checkbox"/> Mouth pain
<input type="checkbox"/> Difficulty swallowing
CARDIOVASCULAR
<input type="checkbox"/> Congestive Heart Failure
<input type="checkbox"/> Chest Pain
<input type="checkbox"/> Faintness
<input type="checkbox"/> Irregular Heartbeat
RESPIRATORY
<input type="checkbox"/> Difficulty Breathing
<input type="checkbox"/> Congestion
<input type="checkbox"/> Dyspnea
<input type="checkbox"/> Wheezing
GASTROINTESTINAL
<input type="checkbox"/> Constipation
<input type="checkbox"/> Diarrhea
<input type="checkbox"/> GERD
<input type="checkbox"/> Nausea
<input type="checkbox"/> Urinary incontinence
<input type="checkbox"/> Vomiting
MUSCULOSKELETAL
<input type="checkbox"/> Arthritis
<input type="checkbox"/> Leg Cramps
<input type="checkbox"/> Muscle Spasm
<input type="checkbox"/> Stiffness
INTEGUMENTARY
<input type="checkbox"/> Skin changes
<input type="checkbox"/> Abrasions
<input type="checkbox"/> Itchy skin
<input type="checkbox"/> Lacerations
NEUROLOGICAL
<input type="checkbox"/> Dizziness
<input type="checkbox"/> Fainting
<input type="checkbox"/> Numbness
<input type="checkbox"/> Paralysis
<input type="checkbox"/> Weakness
ENDOCRINE
<input type="checkbox"/> Change in appetite
<input type="checkbox"/> Kidney disease
<input type="checkbox"/> Night Sweats
<input type="checkbox"/> Excessive urination
HEMATOLOGIC
<input type="checkbox"/> Long term anticoagulant use
<input type="checkbox"/> Bleeding/clotting disorders
<input type="checkbox"/> Sickle Cell Anemia

Past Medical History
(Please check all that applies)

<input type="checkbox"/> Diabetes
<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Stroke/TIA
<input type="checkbox"/> Heart Attack/MI
<input type="checkbox"/> Atrial Fibrillation
<input type="checkbox"/> High Cholesterol
<input type="checkbox"/> High Blood Pressure
<input type="checkbox"/> Seizure Disorder
<input type="checkbox"/> Kidney Disease
<input type="checkbox"/> Kidney Stones
<input type="checkbox"/> Prostate Problems
<input type="checkbox"/> Liver Disease/Hepatitis
<input type="checkbox"/> Asthma
<input type="checkbox"/> Gout
<input type="checkbox"/> Raynaud's
<input type="checkbox"/> Ulcerative Colitis
<input type="checkbox"/> Crohn's Disease
<input type="checkbox"/> Osteoarthritis
<input type="checkbox"/> Rheumatoid Arthritis
<input type="checkbox"/> Back / Spine Problems
<input type="checkbox"/> Fibromyalgia
<input type="checkbox"/> Anemia
<input type="checkbox"/> HIV / AIDS
<input type="checkbox"/> Cancer - type:
<input type="checkbox"/> Anxiety
<input type="checkbox"/> Depression
<input type="checkbox"/> Alcohol Abuse
<input type="checkbox"/> Drug Abuse
<input type="checkbox"/> Thyroid Disorder
<input type="checkbox"/> Reflux / GERD
<input type="checkbox"/> Lyme Disease
<input type="checkbox"/> Osteopenia / Osteoporosis
<input type="checkbox"/> Other medical problems:

Please list all previous surgeries and hospitalizations:

ALLERGIES/REACTION:

<input type="checkbox"/> None
<input type="checkbox"/> Penicillin
<input type="checkbox"/> Sulfa
<input type="checkbox"/> Latex
<input type="checkbox"/> Iodine/Shellfish
<input type="checkbox"/> Tape
<input type="checkbox"/> Local Anesthesia
<input type="checkbox"/> Other:

Referred By:

Occupation:

<input type="checkbox"/> Married	<input type="checkbox"/> Single	<input type="checkbox"/> Partnered
<input type="checkbox"/> Widowed	<input type="checkbox"/> Divorced	
Have you ever used illicit drugs?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Do you ever drink alcohol?	<input type="checkbox"/> Y	<input type="checkbox"/> N
Have you ever used tobacco?	<input type="checkbox"/> Y	<input type="checkbox"/> N <input type="checkbox"/> Quit

List or attach a complete list of all current Medications:

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

To the best of my knowledge, I have answered the questions on this form 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 _____

Signature of Doctor _____ Date _____