Medical History

Name: _____ DOB: _____ Date: _____

Review of Systems
(Please check all that applies)

GASTROINTESTINAL
- ❑ Poor Appetite
- ❑ Weight Loss
- ❑ Weight Gain
- ❑ Excessive Hunger
- ❑ Excessive Thirst
- ❑ Nausea

GENITOURINARY
- ❑ Frequent Urination
- ❑ Painful Urination
- ❑ Kidney Stones

NEUROLOGICAL
- ❑ Weakness
- ❑ Dizziness
- ❑ Numbness
- ❑ Paralysis
- ❑ Fainting

EYES
- ❑ Blurred Vision
- ❑ Eye Inflamation
- ❑ Impaired Site

EARS / NOSE / THROAT
- ❑ Hearing Loss
- ❑ Ear Discharge
- ❑ Nose Bleeding
- ❑ Nose Discharge
- ❑ Sore Throat

CARDIOVASCULAR
- ❑ Chest Pain
- ❑ Feet / Leg Swelling
- ❑ Leg Pain / Cramping
- ❑ Rapid Heart Beat

MUSCULOSKELATAL
- ❑ Joint Pain / Stiffness
- ❑ Muscle Pain

RESPIRATORY
- ❑ Persistent Cough
- ❑ Wheezing
- ❑ Difficulty Breathing
- ❑ Shortness of Breath

INTEGUMENT
- ❑ Itching
- ❑ Skin Rash
- ❑ Deformed Nails
- ❑ Ulcerations

HEMATOLOLIC
- ❑ Bleeding Disorder
- ❑ Taking Coumadin

Past Medical History
(Please check all that applies)

- ❑ Diabetes
- ❑ Glaucoma
- ❑ Stroke/TIA
- ❑ Heart Attack/MI
- ❑ Atrial 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:

Please list all previous surgeries and hospitalizations:

ALLERGIES/REACTION:

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

SOCIAL HISTORY:

❑ Married ❑ Single ❑ Partnered
❑ Widowed ❑ Divorced

Have you ever used illicit drugs? ❑ Y ❑ N

Do you ever drink alcohol? ❑ Y ❑ N

Have you ever used tobacco? ❑ Y ❑ N

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

PRIMARY INSURANCE INFORMATION

Patient Name:_____

Patient Birthdate:_____

Subscriber Name :_____

Relation to Subscriber:(please circle below)

SELF SPOUSE CHILD OTHER

Subscriber Address:_____

_____

Subscriber Birthdate:_____

Subscriber Employer:_____

SECONDARY INSURANCE INFORMATION

Subscriber Name :_____

Relation to Subscriber:(please circle below)

SELF SPOUSE CHILD OTHER

Subscriber Address:_____

_____

Subscriber Birthdate:_____

Subscriber Employer:_____

Use other side of paper if you have a 3rd. insurance. Thank You