Medical History

Name: _____ DOB: _____ Date: _____

Review of Systems
(Please check all that applies)

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

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 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:

Referred By:

Occupation:

❑ 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 ❑ 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