

Name \_\_\_\_\_

Date \_\_\_\_\_

**Please list all your medications:**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_
6. \_\_\_\_\_
7. \_\_\_\_\_
8. \_\_\_\_\_
9. \_\_\_\_\_

**Dates of Previous Illnesses & Hospitalizations**

1. \_\_\_\_\_ Date \_\_\_\_\_
2. \_\_\_\_\_ Date \_\_\_\_\_
3. \_\_\_\_\_ Date \_\_\_\_\_
4. \_\_\_\_\_ Date \_\_\_\_\_
5. \_\_\_\_\_ Date \_\_\_\_\_
6. \_\_\_\_\_ Date \_\_\_\_\_
7. \_\_\_\_\_ Date \_\_\_\_\_
8. \_\_\_\_\_ Date \_\_\_\_\_

**List all Drug Allergies**

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

**SYMPTOMS:**

**Constitutional Symptoms**

- Recent Weight Change Y \_\_\_\_\_ N \_\_\_\_\_
- Fever Y \_\_\_\_\_ N \_\_\_\_\_
- Fatigue Y \_\_\_\_\_ N \_\_\_\_\_
- Headache Y \_\_\_\_\_ N \_\_\_\_\_

**Eyes**

- Wear Glasses/Contacts Y \_\_\_\_\_ N \_\_\_\_\_
- Blurred or Double Vision Y \_\_\_\_\_ N \_\_\_\_\_
- Cataracts Y \_\_\_\_\_ N \_\_\_\_\_

**Ears/Nose/Mouth/Throat**

- Hearing Loss or Ringing Y \_\_\_\_\_ N \_\_\_\_\_
- Earaches or Drainage Y \_\_\_\_\_ N \_\_\_\_\_
- Chronic Sinus Problem/Rhinitis Y \_\_\_\_\_ N \_\_\_\_\_
- Nosebleeds Y \_\_\_\_\_ N \_\_\_\_\_
- Sore Throat or Voice Change Y \_\_\_\_\_ N \_\_\_\_\_
- Swollen Glands in Neck Y \_\_\_\_\_ N \_\_\_\_\_

**Cardiovascular**

- Heart Trouble Y \_\_\_\_\_ N \_\_\_\_\_
- Chest Pain or Angina Y \_\_\_\_\_ N \_\_\_\_\_
- Palpitation Y \_\_\_\_\_ N \_\_\_\_\_
- Shortness of Breath w/ Walking or Lying Flat Y \_\_\_\_\_ N \_\_\_\_\_
- Swelling of Feet, Ankles, or Hands Y \_\_\_\_\_ N \_\_\_\_\_

**Respiratory**

- Chronic or Frequent Coughs Y \_\_\_\_\_ N \_\_\_\_\_
- Spitting up Blood Y \_\_\_\_\_ N \_\_\_\_\_
- Shortness of Breath Y \_\_\_\_\_ N \_\_\_\_\_
- Asthma or Wheezing Y \_\_\_\_\_ N \_\_\_\_\_

**Gastrointestinal**

- Loss of Appetite Y \_\_\_\_\_ N \_\_\_\_\_
- Nausea or Vomiting Y \_\_\_\_\_ N \_\_\_\_\_
- Frequent Diarrhea Y \_\_\_\_\_ N \_\_\_\_\_
- Painful Bowel Movements or Constipation Y \_\_\_\_\_ N \_\_\_\_\_
- Rectal Bleeding or Blood in Stool Y \_\_\_\_\_ N \_\_\_\_\_
- Abdominal Pain or Heartburn Y \_\_\_\_\_ N \_\_\_\_\_
- Peptic Ulcer Y \_\_\_\_\_ N \_\_\_\_\_

**FAMILY HISTORY** Check all that apply to your family--

(Father, Mother, Sister, Brother)

- |                           |                      |
|---------------------------|----------------------|
| _____ High Blood Pressure | _____ Cancer         |
| _____ Stroke              | _____ Kidney Disease |
| _____ Asthma              | _____ Diabetes       |
| _____ Heart Disease       |                      |

**SYMPTOMS CONTINUED:**

**Genitourinary**

- Frequent Urination Y \_\_\_\_\_ N \_\_\_\_\_
- Burning or Painful Urination Y \_\_\_\_\_ N \_\_\_\_\_
- Blood in Urine Y \_\_\_\_\_ N \_\_\_\_\_
- Incontinence or Dribbling Y \_\_\_\_\_ N \_\_\_\_\_
- Female-Pain w/ Periods Y \_\_\_\_\_ N \_\_\_\_\_
- Female-Irregular Periods Y \_\_\_\_\_ N \_\_\_\_\_
- Female-Vaginal Discharge Y \_\_\_\_\_ N \_\_\_\_\_
- Female-Date of Last Pap Smear \_\_\_\_\_ / \_\_\_\_\_
- Female-Last Menstrual Period \_\_\_\_\_ / \_\_\_\_\_

**Musculoskeletal**

- Joint Pain Y \_\_\_\_\_ N \_\_\_\_\_
- Joint Stiffness or Swelling Y \_\_\_\_\_ N \_\_\_\_\_
- Weakness of Muscles or Joints Y \_\_\_\_\_ N \_\_\_\_\_
- Muscle Pain or Cramps Y \_\_\_\_\_ N \_\_\_\_\_
- Back Pain Y \_\_\_\_\_ N \_\_\_\_\_

**Integumentary (Skin or Breasts)**

- Rash or Itching Y \_\_\_\_\_ N \_\_\_\_\_
- Change in Skin Color Y \_\_\_\_\_ N \_\_\_\_\_
- Change in Hair or Nails Y \_\_\_\_\_ N \_\_\_\_\_
- Varicose Veins Y \_\_\_\_\_ N \_\_\_\_\_

**Neurological**

- Frequent or Recurring Headaches Y \_\_\_\_\_ N \_\_\_\_\_
- Lightheaded or Dizzy Y \_\_\_\_\_ N \_\_\_\_\_
- Convulsions or Seizures Y \_\_\_\_\_ N \_\_\_\_\_
- Numbness or Tingling Sensations Y \_\_\_\_\_ N \_\_\_\_\_
- Tremors Y \_\_\_\_\_ N \_\_\_\_\_
- Paralysis Y \_\_\_\_\_ N \_\_\_\_\_
- Stroke Y \_\_\_\_\_ N \_\_\_\_\_

**Psychiatric**

- Memory Loss or Confusion Y \_\_\_\_\_ N \_\_\_\_\_
- Nervousness Y \_\_\_\_\_ N \_\_\_\_\_
- Depression Y \_\_\_\_\_ N \_\_\_\_\_
- Insomnia Y \_\_\_\_\_ N \_\_\_\_\_

**Endocrine**

- Thyroid Disease Y \_\_\_\_\_ N \_\_\_\_\_
- Diabetes Y \_\_\_\_\_ N \_\_\_\_\_
- Excessive Thirst or Urination Y \_\_\_\_\_ N \_\_\_\_\_
- Heat or Cold Intolerance Y \_\_\_\_\_ N \_\_\_\_\_

**Hematological/Lymphatic**

- Bleeding or Bruising Tendency Y \_\_\_\_\_ N \_\_\_\_\_
- Anemia Y \_\_\_\_\_ N \_\_\_\_\_
- Phlebitis Y \_\_\_\_\_ N \_\_\_\_\_
- Past Transfusion Y \_\_\_\_\_ N \_\_\_\_\_

**Allergic/Immunologic**

- History of Skin Reaction or Other Adverse Reaction to:
- Penicillin or Other Antibiotics Y \_\_\_\_\_ N \_\_\_\_\_
- Morphine, Demerol, or Other Narcotics Y \_\_\_\_\_ N \_\_\_\_\_
- Aspirin or Other Pain Remedies Y \_\_\_\_\_ N \_\_\_\_\_
- Influenza Vaccine or Other Serums Y \_\_\_\_\_ N \_\_\_\_\_

Date \_\_\_\_\_

Signed \_\_\_\_\_ MD