

Name _____ Birth Date _____ Today's Date _____

Reason for your visit _____

If you have had any of the following medical problems with or without surgery please check and describe below.

- | | | |
|--|--|-------------------------------|
| <input type="checkbox"/> Lung trouble / Emphysema | <input type="checkbox"/> Anemia | Allergies |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bleeding Disorder | Penicillin _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Blood Clots | Novocain _____ |
| <input type="checkbox"/> Heart Attack / Angina | <input type="checkbox"/> Diabetes | Iodine dye _____ |
| <input type="checkbox"/> Liver Trouble / Cirrhosis | <input type="checkbox"/> Arthritis | Sulfa _____ |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Gout | Latex (rubber) _____ |
| <input type="checkbox"/> Kidney trouble | <input type="checkbox"/> Cancer | Tape _____ |
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Epilepsy / Seizures | Others _____ |
| <input type="checkbox"/> Others-explain below | <input type="checkbox"/> Thyroid trouble | No Known Drug Allergies _____ |

Do you Smoke? YES _____ NO _____ How often _____ How many years _____
 Do you drink alcohol? YES _____ NO _____ What _____ How many per week _____

Medical Problems

Previous Surgery with dates

Medications dosage how often

Other Comments

PLEASE TURN OVER

NAME _____

DATE _____

REVIEW OF SYMPTOMS: Please circle any current symptoms you have.

Constitutional	Respiratory	Skin
Recent fevers/sweats	Cough/wheeze	Rash
Unexplained weight loss/pain	Coughing up blood	New or change in mole
Unexplained fatigue/weakness		
Eyes	Gastrointestinal	Neurological
Change in vision	Heartburn/reflux	Headaches
	Blood/change in bowel move.	Memory Loss
	Nausea/vomitting/diarrhea	Fainting
Ears/Nose/Throat/Mouth	Pain in abdomen	
Difficulty hearing/ringing in ears	Genitourinary	Psychiatric
Hay fever/allergies/congestion	Painfull /bloody urination	Anxiety/stress
Trouble swallowing	Leaking urine	Sleep problem
	Nighttime urination	
Cardiovascular	Discharge: penis or vaginal	Blood/Lymphatic
	Unusual vaginal bleeding	
Chest pains/discomfort	Concern with sexual functions	Unexplained lumps
Palpitations		Easy bruising/bleeding
Sort of breath with exertion		
Breast	Musculoskeletal	Endo
Breast lump	Muscle/joint pain	Cold/heat intolerance
Nipple discharge	Recent back pain	Increase thirst/appetite

FAMILY HISTORY: Please indicate the current status of your immediate family members.
Please indicate family members (parent, sibling, grandparent, aunt or uncle).

Alcoholism _____	High cholesterol _____
Cancer, specify type _____	High blood pressure _____
Heart disease _____	Stroke _____
Depression/Suicide _____	Bleeding or clotting disorder _____
Genetic disorder _____	Asthma/COPD _____
Diabetes _____	Other _____