Patient Name: **Date:**

****Please complete this form entirely**

Are you allergic to any medications? NO □ Yes □ Please list:

Past Medical History

Diabetes	□	Osteoporosis	□	Blood clots	□
Chest Pain/Angina	□	Asthma/COPD	□	Peripheral Vascular Disease	□
High Blood Pressure	□	Stroke/CVA/TIA	□	Tuberculosis	□
Heart Disease	□	Seizures	□	Depression	□
Heart Attack	□	HIV/AIDS	□	Congestive Heart Failure	□
High Cholesterol	□	Hepatitis	□	Thyroid Disease	□
Pacemaker	□	Stomach Ulcer	□		
Headaches	□	Liver Disease	□		
Kidney Stones	□	Heart Palpitations	□		
Kidney Disease	□	Arthritis	□		
Cancer	□	Heart Disease	□		

Current Medications

Other (please list below)

ROS	(-)	Please check all **CURRENT** positive findings
Constitutional		Weight loss □ Fevers □ Chills □ Poor appetite □ Fatigue □ Weight gain □ Insomnia □ Night sweats □
Eyes		Blurry Vision □ Eye pain □ Eye discharge □ Eye redness □ Decrease in vision □ Dry eyes □ Double vision □
ENT		Sore throat □ Hoarseness □ Ear pain □ Hearing loss □ Ear discharge □ Nose bleeds □ Tinnitus □ Sinus Problems □
Cardiovascular		Chest pain □ Palpitations □ Rapid heart rate □ Heart murmur □ Poor circulation □ Swelling in legs or feet □
Respiratory		Shortness of breath □ Chronic cough □ Coughing up blood □ History of Tuberculosis □ Excess sputum production □
Gastrointestinal		Nausea □ Vomiting □ Diarrhea □ Constipation □ Blood in the stool □ Frequent heartburn □ Trouble swallowing □
Genitourinary		Increased urinary frequency □ Blood in the urine □ Incontinence □ Painful urination □ Urinary retention □ Frequent UTI's □
Skin		Rash □ Hives □ Hair loss □ Skin sores or ulcers □ Itching □ Skin thickening □ Nail changes □ Moles changes □
Musculoskeletal		Joint pain □ Muscle aches □ Frequent leg cramps □ Muscle weakness □ Bone pain □ Joint swelling □ Back pain □
Psychiatric		Anxiety □ Depression □ Alcohol or drug dependence □ Suicidal thoughts □ Panic attacks □ Use of anti-depressants □
Endocrine		Goiter □ Heat intolerance □ Cold intolerance □ Increased thirst □ Change in skin pigment □ Excessive sweating □
Neurological		Seizures □ Tremors □ Migraines □ Numbness □ Dizziness/Vertigo □ Loss of Balance □ Slurred speech □ Stroke □
Hem/Lymphatic		Low blood count □ Easy bruising □ Swollen lymph nodes □ Transfusions □ Prolonged bleeding □ Blood clots □
Allergic/Immun		Allergic reactions □ Hay fever □ Frequent infections □ Hepatitis □ HIV positive □ Positive tuberculin skin test (PPD) □

Social History: Marital Status _____ Occupation (or most recent job held) _____

Non-Smoker (never smoked) □ Ex-Smoker □ Current Smoker □ How many packs per day?_____

Alcohol consumption: Never □ Occasional □ Frequent □

Family History: (Please list any know medical problems)

Father: _____ Mother: _____

Siblings: _____

Your Children: _____

Additional Information: Use this space to provide any additional information which may be important to your health care.

_____ _____

Signature of Reviewing Physician Date **Signature of Patient** **Date**

(I have personally discussed these findings with the patient)