**Name:**

| **Allergies:** | **Name of medication** | **Reaction** |
|---|---|---|
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

| **Medications:** | **Prescription/Dosage/Frequency** | **For what condition** |
|---|---|---|
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |
| | _____ | _____ |

**Surgeries:** _____, _____, _____

_____, _____, _____

**Tobacco/smoking:** **Present use** _____ **Past use** _____

**Alcohol type and amount:** _____

**Family History- Document what family members have the following medical conditions:**

| | |
|---|---|
| Heart Diseases | Cancer (what type) |
| Diabetes | High blood pressure |
| High Cholesterol | Asthma |
| Stroke | |

OTHERS:

**What Immunization have you had in the last 10 years and when?**

Last Flu shot? Last Tdap?

**NAME:**

**General/Constitutional**

| | | |
|---|---|---|
| Yes | No | Weight gain |
| Yes | No | Weight loss |
| Yes | No | Mood change |
| Yes | No | Difficulty sleeping |
| Yes | No | Fatigue |

**Eyes (circle yes or no)**

| | | |
|---|---|---|
| Yes | No | Blurred vision |
| Yes | No | Eye irritation/itching |

**ENMT**

| | | |
|---|---|---|
| Yes | No | Change in hearing |
| Yes | No | Ear pain |
| Yes | No | Nose bleeds |
| Yes | No | Sinus/nasal congestion |
| Yes | No | Difficulty swallowing |
| Yes | No | Hoarseness |

**Cardiovascular**

| | | |
|---|---|---|
| Yes | No | Chest pain |
| Yes | No | Heart trouble |
| Yes | No | Heart murmur |
| Yes | No | Palpitations |
| Yes | No | Swelling |

**Respiratory**

| | | |
|---|---|---|
| Yes | No | Difficulty breathing |
| Yes | No | Wheezing |
| Yes | No | Chest congestion |
| Yes | No | Cough |

**Endocrine**

| | | |
|---|---|---|
| Yes | No | Excessive appetite |
| Yes | No | Excessive sweating |
| Yes | No | Weight change |

**Allergy to medication**
**if yes what type of medication and reaction?**

Yes No _____

**Hematologic/Lymphatic**

| | | |
|---|---|---|
| Yes | No | anemia |

**Gastrointestinal**

| | | |
|---|---|---|
| Yes | No | Abdominal pain |
| Yes | No | Nausea |
| Yes | No | Vomiting |
| Yes | No | Constipation |
| Yes | No | Diarrhea |
| Yes | No | Blood in the stool |

**musculoskeletal**

| | | |
|---|---|---|
| Yes | No | Limited joint mobility |
| Yes | No | Joint pain |
| Yes | No | Neck pain |
| Yes | No | Back pain |

**Integumentary**

| | | |
|---|---|---|
| Yes | No | Hives |
| Yes | No | Skin lump/mass |
| Yes | No | Mole changes |
| Yes | No | Piercings |
| Yes | No | Sores |
| Yes | No | Rash |
| Yes | No | Nail changes |

**Neurological**

| | | |
|---|---|---|
| Yes | No | Headaches |
| Yes | No | Seizure |
| Yes | No | Fainting |
| Yes | No | Dizziness upon standing |
| Yes | No | Ringing in the ears |
| Yes | No | Numbness/tingling |
| Yes | No | Muscle weakness |
| Yes | No | Loss of muscle bulk |

**Psychiatric**

| | | |
|---|---|---|
| Yes | No | Anxiety |
| Yes | No | Depression |
| Yes | No | Stress |
| Yes | No | History of IV drug use |

**Male**

| | | |
|---|---|---|
| Yes | No | Night time urination |
| Yes | No | Difficulty urinating |
| Yes | No | Blood in urine |
| Yes | No | Testicular problems |
| Yes | No | Erectile dysfunction |

| | | |
|---|---|---|
| Yes | No | Swollen glands |

**Female**

| | | |
|---|---|---|
| Yes | No | Breast pain |
| Yes | No | Age Menarche |
| Yes | No | Pregnancies |
| Yes | No | Taking Hormones |
| Yes | No | History of breast Cancer |
| Yes | No | History Ovarian Cancer |
| Yes | No | vagina discharge |

**FDLMP:** _____