

UPDATES – Were any changes made to this form?

Name: _____

Date _____ Patient's Initial _____ Yes No MD/NP/PA

Date: _____ Age: _____ Sex: M F

Primary Physician: _____

Referring / Requesting Physician: _____

REVIEW OF SYSTEMS: (Please check all that apply for yourself)

NONE

General Current:

- Fever
 Chills
 Rash
 Flu Symptoms
 Night Sweats

ENT:

- Poor Vision
 Cataracts
 Hearing Loss
 Swallowing Difficulties
 Meniere's Disease

Pulmonary:

- COPD/Emphysema
 Asthma
 Chronic Bronchitis

Gastrointestinal:

- Stomach Ulcer
 Ulcerative Colitis
 Reflux/Heartburn
 Crohn's disease

Integumentary:

- Ehlers-Danlos
 Psoriasis
 Tick Bites
 MRSA
 Other Rashes

Genitourinary:

- Kidney Failure
 Kidney Stones
 Kidney Disease
 Dysuria (painful urination)
 Prostate Disease

Hematological:

- Sickle Cell
 Thalassemia
 Bleeding Disorder
 Hepatitis

Endocrine:

- Lupus
 Thyroid Disease
 Adrenal Disease
 Pituitary Disease

Neurological:

- Stroke
 TIA
 Seizure
 Multiple Sclerosis
 Parkinson's Disease

Psychiatric:

- Depression
 Bipolar Disorder
 Schizophrenia
 Anxiety

Cardiovascular:

- Pacemaker
 Chest Pain
 Heart Murmur
 Heart Attack
 Heart Valve Disease
 Irregular Heart Beat
 Increased Cholesterol
 High Blood Pressure

Musculoskeletal:

- Rheumatoid Arthritis
 Osteoarthritis
 Osteoporosis
 Fibromyalgia
 Lyme's Disease
 Pain in joints
 Gout

Other Diagnosed Conditions:

- Cancer, which type/where? _____ Treatment _____
 Diabetes, controlled with: insulin oral medication diet
 Blood clot DVT Pulmonary emboli

Any other conditions for which you take medication: _____

Drug Allergies: _____

Current Medications with dosage and frequency. If more space is needed, please use the Medication Form available at the front desk: See attached list:

Past Surgeries / Hospitalizations: _____

SOCIAL HISTORY:

Employer/Occupation: _____ Full time Part time Retired Student, grade: _____

Height: _____ feet _____ inches Weight: _____ pounds Recent weight gain/loss, amount? _____

Marital Status: Minor Married Widowed Divorced Separated Single

Do you drink alcohol? Never Rarely Socially Moderately Heavy drinker Recovering alcoholic

Do you smoke? Never Currently, amount? _____ Former smoker, quit when? _____

FAMILY HISTORY: (Any serious medical problems of blood relatives, including dates and cause of death of parents/grandparents, if deceased)

- Cancer High Blood Pressure
 Diabetes Liver Disease
 Stroke Kidney Disease
 Lung Problems Heart Problems/Attack

Details and Other Inherited Diseases: _____

Patient Signature: _____ Date: _____

History reviewed by: _____ Date: _____