Name _____ Gender _____ Age _____

Date of Appointment: _____

Reason for Visit

What brings you to the office today?

How is your general health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Do you have any other concerns you would like to address?

Current Medications

What medications are you currently taking?

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Name _____ Dosage _____ Frequency _____

Allergies

Are you allergic to any of the following?

☐ Adhesive Tape ☐ Antibiotics ☐ Latex
☐ Barbiturates (Sleeping Pills) ☐ Aspirin ☐ Iodine
☐ Codeine ☐ Sulfa ☐ Local Anesthetics

Do you have any other allergies?

Name _____ Reaction _____

Name _____ Reaction _____

Past Medical History

☐ Alcoholism ☐ Back Problems ☐ Ear Problems
☐ Allergies ☐ Bleeding Disorder ☐ Eating Disorder
☐ Anemia ☐ Blood Disease ☐ Epilepsy
☐ Anxiety Disorder ☐ Blood Transfusion ☐ Glaucoma
☐ Arthritis ☐ Cancer ☐ Gout
☐ Asthma ☐ Diabetes ☐ Heart Disease
☐ AIDS / HIV ☐ Depression ☐ Heart Problems
☐ Hepatitis - A, B, or C ☐ Measles ☐ Skin Disorder
☐ High Blood Pressure ☐ Migraines ☐ Stomach Ulcer
☐ High Cholesterol ☐ Osteoporosis ☐ Substance Abuse
☐ Joint Disorder ☐ Pneumonia ☐ Thyroid Disorder
☐ Kidney Disorder ☐ Polio ☐ Tuberculosis
☐ Liver Disorder ☐ Rheumatic Fever ☐ Venereal Disease
☐ Lung Disease ☐ Stroke

Hospitalizations & Surgeries

Reason _____ Date _____

Reason _____ Date _____

Women Only:

of Pregnancies _____ # of Miscarraiges _____ # of Abortions _____ # of Living _____

Last Pap Smear _____ Last Mammogram _____ Birth Control Method _____

Family History

Has anyone in your family ever had any of the following conditions?

☐ Alcoholism ☐ Cancer ☐ Joint Disorder
☐ Allergies ☐ Depression ☐ Kidney Disease
☐ Alzheimer's ☐ Diabetes ☐ Liver Disorder
☐ Anemia ☐ Epilepsy ☐ Lung Disease
☐ Anxiety ☐ Genetic Disorder ☐ Migraines
☐ Arthritis ☐ Glaucoma ☐ Psychiatric Disorders
☐ Asthma ☐ Heart Disease ☐ Osteoporosis
☐ AIDS/HIV ☐ Hepatitis ☐ Stroke
☐ Bleeding Disorder ☐ High Cholesterol ☐ Substance Abuse
☐ Blood Disorder ☐ High Blood Pressure ☐ Thyroid Disorder

Details: _____

Lifestyle Factors

Are you sexually active?

☐ Yes ☐ No # of partners in past year _____

Do you wish to be checked for STDs?

☐ Yes ☐ No

Has anyone in your home ever physically or verbally hurt you?

☐ Yes ☐ No

Have you ever smoked?

☐ Yes ☐ No # of years _____ # packs/day _____

Do you smoke now?

☐ Yes ☐ No # packs/day _____

Do you use recreational drugs?

☐ Yes ☐ No types? _____ # times/week _____

How much alcohol do you drink per week?

drinks/week _____

How much caffeine do you drink per day?

drinks/day _____

How often do you exercise?

times/week _____

Name _____ Gender _____ Age _____ Date of Appointment: _____

Review of Systems

General
- ☐ Chills
- ☐ Dizziness
- ☐ Fainting
- ☐ Fever
- ☐ Hair Loss
- ☐ Hair Growth – Excessive
- ☐ Night Sweats
- ☐ Sleeping Problems
- ☐ Thirst - Excessive
- ☐ Weight Gain
- ☐ Weight Loss

Mental Health
- ☐ Anxiety
- ☐ Depression
- ☐ Loss of Interest
- ☐ Feeling Hopeless
- ☐ Hearing Voices
- ☐ Marital Problems
- ☐ Panic Attacks
- ☐ Trouble Concentrating
- ☐ Suicide –Thoughts/Attempts

Skin
- ☐ Acne
- ☐ Bruise Easily
- ☐ Changes in Moles
- ☐ Chills
- ☐ Dry / Sensitive Skin
- ☐ Eczema
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Scars
- ☐ Sores That Won't Heal

Gastrointestinal
- ☐ Appetite Gain
- ☐ Appetite Loss
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Intestinal Disorder
- ☐ Lactose Intolerance
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Genitourinary
- ☐ Blood in Urine
- ☐ Lack of Bladder Control
- ☐ Frequent Urination
- ☐ Painful Urination

Neurological
- ☐ Coordination Problems
- ☐ Convulsions
- ☐ Difficulty Walking
- ☐ Learning Disabilities
- ☐ Light-headedness
- ☐ Memory Loss
- ☐ Numbness / Tingling
- ☐ Paralysis
- ☐ Seizures
- ☐ Speech Problems
- ☐ Tremors

ENT
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earaches
- ☐ Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Hearing Loss
- ☐ Nose-Bleeds
- ☐ Persistent Cough
- ☐ Persistent Runny Nose
- ☐ Recurring Sore Throat
- ☐ Ringing in Ears
- ☐ Sinus Problems
- ☐ Vision Halos

Respiratory
- ☐ Coughing
- ☐ Coughing Up Blood
- ☐ Shortness of Breath
- ☐ Wheezing

Cardiovascular
- ☐ Chest Pains
- ☐ Irregular Heart Beat
- ☐ Circulation Problems
- ☐ Heart Palpitations
- ☐ Rapid Heartbeat
- ☐ Swelling of Ankles
- ☐ Varicose Veins

Musculoskeletal
- ☐ Back Pain
- ☐ Carpal Tunnel Syndrome
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Neck Pain
- ☐ Shoulder Pain

Men Only
- ☐ Erection Difficulties
- ☐ Lump in Testicles
- ☐ Penile Discharge
- ☐ Sore on Penis

Women Only
- ☐ Abnormal Pap Smear
- ☐ Bleeding between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple Discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge

Other Symptoms

_____

_____

_____

Health Exams & Procedures

Please check and date the last time you had each exam or procedure performed.

	Month & Year		Month & Year
☐ Cholesterol Test	_____	☐ MRI	_____
☐ Colonoscopy	_____	☐ Physical Exam	_____
☐ CT/CAT Scan	_____	☐ Cardiac Stress Test	_____
☐ EKG	_____	☐ Ultra Sound	_____
☐ Echocardiogram	_____		

Immunizations

Please check and date all immunizations you have had.

	Month & Year		Month & Year
☐ Hepatitis A	_____	☐ MMR (Measles, Mumps, Rubella)	_____
☐ Hepatitis B (Series of 3)	_____	☐ Pneumonia	_____
☐ HPV Vaccine	_____	☐ Polio	_____
☐ Influenza (Flu Shot)	_____	☐ Tetanus	_____
☐ Meningitis	_____		