Patient Name: _____ **Date:** _____

Past Medical History

	Yes	No
Diabetes	☐	☐
High Blood Pressure	☐	☐
Heart Disease	☐	☐
High Cholesterol	☐	☐
Thyroid disease	☐	☐
Asthma/COPD	☐	☐
Stroke/CVA/TIA	☐	☐
Seizures	☐	☐
HIV/AIDS	☐	☐

	Yes	No
Kidney Stones	☐	☐
Kidney Disease	☐	☐
Cancer Type:_____	☐	☐
Hepatitis	☐	☐
Liver Disease	☐	☐
Blood Clots	☐	☐
Arthritis	☐	☐
Pneumonia Vaccine	**Y**	**N**

Past Surgical History

Surgery	**Year**
_____	
_____	
_____	
_____	
_____	
_____	
_____	

Colonoscopy **Y** **N**

Will you accept blood transfusions? **Y** **N**

Current Medications Including Supplements

Name	Dose	How Often
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Drug Allergies

Drug Name	Reaction
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Systems Review	(-)	**Please check all CURRENT positive findings**			
Constitutional		Weight Loss ☐	Fevers ☐	Chills ☐	Fatigue ☐
Eyes		Blurry Vision ☐	Eye pain ☐	Double Vision ☐	
ENT		Sore throat ☐	Hoarseness ☐	Ear pain ☐	
Cardiovascular		Chest pain ☐	Palpitations ☐	Heart murmur ☐	
Respiratory		Shortness of breath ☐	Chronic cough ☐	Coughing up blood ☐	
Gastrointestinal		Nausea ☐	Vomiting ☐	Diarrhea ☐	Blood in stool ☐
Genitourinary		Increased urinary frequency ☐	Blood in the urine ☐	Incontinence ☐	Painful urination ☐
Skin		Rash ☐	Hair loss ☐	Itching ☐	
Musculoskeletal		Joint pain ☐	Muscle aches ☐	Bone pain ☐	
Psychiatric		Anxiety ☐	Depression ☐	Alcohol or drug dependence ☐	
Endocrine		Heat intolerance ☐	Cold intolerance ☐	Increased thirst ☐	
Neurological		Seizures ☐	Tremors ☐	Stroke ☐	
Hem/Lymphatic		Easy bruising ☐	Blood clots ☐		
Immune System		Allergic reactions ☐	Hepatitis ☐	HIV positive ☐	

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 ☐ When did you quit smoking?____

Family History: (Please list any known 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