

Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**Symptoms**

Please check the box of any problem or concern related to the following symptoms that have been persistent or recurring since your last visit.

**Constitutional symptoms**

- Fever/Chills
- Fatigue
- Weight loss/gain (>5 lbs.)

**Eyes/Ears/Nose/Throat**

- Vision change
- Pain
- Hearing change
- Vertigo
- Sinus congestion/pressure
- Swelling or lumps in throat

**Cardiovascular**

- Chest pain
- Palpitations
- Edema/swelling in legs

**Respiratory**

- Shortness of breath
- Coughing

**Abdomen (GI/GU)**

- Abdominal pain
- Constipation

- Diarrhea
- Blood in stool/discolored stool
- Heartburn or indigestion
- Difficulty swallowing
- Nausea/vomiting
- Change in frequency of urination

**Musculoskeletal**

- Back pain/neck pain
- Joint pain or swelling
- Muscle pain

**Skin**

- Rash
- Skin growth
- New or changed moles
- Persistent itch

**Neurological**

- Headaches - frequent or severe
- Change in thinking, confusion
- Memory loss
- Trouble speaking
- Weakness

- Loss of coordination, falling
- Change in sensation-numbness

**Psychiatric**

- Change in mood or anxiety
- Trouble sleeping

**Endocrine**

- Excessive/increased thirst
- Heat/cold intolerance
- Too hot/cold

**Hematological/Lymphatic**

- Blood clotting problems
- Easy bruising or bleeding
- Enlarged lymph nodes

**Allergy/Immune System**

- Environmental allergies
- Drug allergies

**Medications**

Please list both prescription and non-prescription medications you are currently taking:

Medication	Dose	Times/day	Medication	Dose	Times/day
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

**Allergies**

Do you have any drug or environmental allergies?  No  Yes If YES, please list below and describe reaction.

- Reaction: \_\_\_\_\_
- Reaction: \_\_\_\_\_
- Reaction: \_\_\_\_\_
- Reaction: \_\_\_\_\_



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**Surgeries**

- |   |   |  |  |
|---|---|--|--|
| <input type="checkbox"/> No Surgical History    | <input type="checkbox"/> Mastectomy           | <input type="checkbox"/> Appendectomy      | <input type="checkbox"/> Hysterectomy  |
| <input type="checkbox"/> C-Section              | <input type="checkbox"/> Abdominal surgery    | <input type="checkbox"/> Joint replacement | <input type="checkbox"/> Sterilization |
| <input type="checkbox"/> Breast biopsy          | <input type="checkbox"/> Hernia repair        | <input type="checkbox"/> Cosmetic surgery  | <input type="checkbox"/> Other _____   |
| <input type="checkbox"/> Broken bones/fractures | <input type="checkbox"/> Gall bladder removal | <input type="checkbox"/> Colon removal     | _____                                  |
| <input type="checkbox"/> CABG/Heart Bypass      | <input type="checkbox"/> Tonsillectomy        | <input type="checkbox"/> Brain             | _____                                  |

**Family Medical History** Please check each that apply and list the relationship of family member.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Cancer _____   | <input type="checkbox"/> Seizures _____         | <input type="checkbox"/> High Blood Pressure _____ |
| <input type="checkbox"/> Asthma _____   | <input type="checkbox"/> Migraines _____        | <input type="checkbox"/> Thyroid Disease _____     |
| <input type="checkbox"/> Stroke _____   | <input type="checkbox"/> Heart Problems _____   | <input type="checkbox"/> Clotting Disorder _____   |
| <input type="checkbox"/> HIV/AIDS _____ | <input type="checkbox"/> High Cholesterol _____ | <input type="checkbox"/> Alcoholism _____          |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Skin Problems _____    |  |
| Arthritis _____                         | <input type="checkbox"/> Kidney Disease _____   |  |