



Name: _____ **Birthdate:** ___ / ___ / ___ **Date:** ___ / ___ / ___

What is the reason for your visit today? _____

How long has this been a problem? _____

What treatments have been tried? _____

PATIENT HISTORY

Have **you** ever had or do you have:

- | | | |
|---|--|--|
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Epilepsy/Seizures | <input type="checkbox"/> HIV(AIDS) |
| <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Pulmonary embolus |
| <input type="checkbox"/> Hereditary Disease
(list) _____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Mental Illness | _____ |
| <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Stroke | |
| | <input type="checkbox"/> Thyroid problem | |

Please List:

Allergies to Medication/Food/Latex : _____

Current Medications (name, dosage, frequency):

_____	_____
_____	_____
_____	_____
_____	_____

Surgeries and Hospitalizations:

_____	_____
_____	_____
_____	_____
_____	_____

FAMILY HISTORY

Has anyone in your **family** (mother, father, siblings, grandparents) had:

- | | | |
|--|--|--|
| <input type="checkbox"/> Anesthesia Problems | <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Cancer: _____ | <input type="checkbox"/> Thyroid problem |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Hereditary Disease | <input type="checkbox"/> Mental Illness | _____ |

Name: _____ Birthdate: ___ / ___ / ___ Date: ___ / ___ / ___

SOCIAL HISTORY

Do You:

- Use Tobacco (circle: Cigarettes/ Cigars/ Pipe/ Snuff/ Chew)
How much daily _____ (packs) for how many years ____ Quit date _____
- Use Alcohol (circle: Beer/ Wine/ Liquor)
How often: _____
- Use Drugs
How often: _____

REVIEW OF SYSTEMS (please circle)

- General:** Fever, chills, weight loss, night sweats
- Ears:** Hearing loss, pain, ringing, dizziness, frequent infections
- Nose:** Bleeding, congestion, post-nasal drip, loss of smell, injury
- Throat:** Frequent sore throats, hoarseness, difficulty swallowing, pain
- Eyes:** Vision changes, cataracts, glaucoma
- Heart:** Chest pain, heart murmur, heart palpitations, ankle swelling, pacemaker
- Lungs:** Wheezing, shortness of breath, cough, bronchitis, pneumonia
- GI:** Heartburn, ulcers, diarrhea, nausea, vomiting, liver problems
- GU:** Painful urination, bloody urination, kidney stones
- Musc:** Arthritis, weakness of limbs, tingling, back pain, TMJ/jaw
- Neuro/Psych:** Depression, anxiety/panic, headaches, numbness
- Endocrine:** Menopause, pregnancy, hormone replacement
- Blood:** excessive bleeding, blood clots, easy bruising, DVT
- Allergy:** Itchy eyes, runny nose, previous allergy testing, food allergies, hives

Patient Signature: _____ **Date:** _____

Reviewed By: _____ Date: _____