Name of Patient: ______________________________ Date: ______________

Chief Complaints: ______________________________

**MEDICATIONS:**

List all current prescription, non-prescription medications, vitamins, and herbal products. Please INCLUDE even occasional use of aspirin or anti-inflammatory medication for arthritis.

| Name of Medication | Strength | Frequency Taken |
| --- | --- | --- |
| ______________ | ______________ | ______________ |
| ______________ | ______________ | ______________ |
| ______________ | ______________ | ______________ |
| ______________ | ______________ | ______________ |
| ______________ | ______________ | ______________ |
| ______________ | ______________ | ______________ |

**PATIENT'S MEDICAL HISTORY** (active or inactive) Check those that are applicable

**-GI-**
- ☐ Gallstones
- ☐ Pancreatitis
- ☐ Peptic Ulcer Disease
- ☐ Hepatitis
- ☐ Irritable Bowel Syndrome
- ☐ Reflux, GERD

**-CANCER-**
- ☐ Breast
- ☐ Skin
- ☐ Prostate
- ☐ Colon
- ☐ Other: ______________

**-Heart/Lung-**
- ☐ Angina
- ☐ Heart Attack
- ☐ Congestive Heart Failure
- ☐ Mitral Valve Prolapse
- ☐ Heart Valve Disease
- ☐ Atrial Fibrillation
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Stroke
- ☐ Asthma
- ☐ COPD; Emphysema
- ☐ Sleep Apnea

**-Metabolic/Misc.**
- ☐ Kidney Stones
- ☐ Chronic Renal Failure
- ☐ Headaches
- ☐ Diabetes Mellitus
- ☐ Seizures
- ☐ Chronic Fatigue Syndrome
- ☐ Fibromyalgia
- ☐ Rheumatoid Arthritis
- ☐ Osteoarthritis/DJD
- ☐ Osteoporosis
- ☐ Glaucoma
- ☐ Depression
- ☐ Bipolar Disorder

**Other medical problems not listed above:**

______________________________

______________________________

**ALLERGIES:** ☐ NONE

INCLUDE allergies to medications and other medical products (examples: tape, latex, and iodine).

Name of Medicine or Product & Description of Reaction:

______________, ______________, ______________

Do you have any implantable devices: Yes__________ (Please give front desk your card) No__________

**HOSPITALIZATION:** ☐ NONE ☐ YES Hospital Name & Why were you hospitalized.

Name Hospital: ______________ Reason: ______________

______________ ______________

## SURGICAL HISTORY

☐ None

| Type of Surgery and Reason | Year |
|---|---|
| | |
| | |
| | |

## FAMILY HEALTH HISTORY

| | Age (if living) | HEALTH PROBLEMS | | AGE | HEALTH PROBLEMS |
|---|---|---|---|---|---|
| **Father** | | | **Children** | ☐ M ☐ F | |
| **Mother** | | | | ☐ M ☐ F | |
| **Sibling** | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | | ☐ M ☐ F | |
| | ☐ M ☐ F | | **Grandmother** *Maternal* | | |
| | ☐ M ☐ F | | **Grandfather** *Maternal* | | |
| | ☐ M ☐ F | | **Grandmother** *Paternal* | | |
| | ☐ M ☐ F | | **Grandfather** *Paternal* | | |

## HEALTH HABITS AND PERSONAL SAFETY

Do you drink alcohol? ☐ Yes ☐ No

If yes, what kind? ______________________________________________

How many drinks per week? ____________________

Do you use tobacco? ☐ Yes ☐ No

☐ Cigarettes – pks. /day_______ ☐ Chew - #/day_____ ☐ Pipe - #/day________ ☐ Cigars - #/day_______

☐ # of year's __________ ☐ or year quit ____________

Do you currently use recreational or street drugs? ☐ Yes ☐ No

Have you ever given yourself street drugs with a needle? ☐ Yes ☐ No

Do you drink caffeine? ☐ Yes ☐ No

Do you live alone? ☐ Yes ☐ No

Do you live in an assisted living facility? ☐ Yes ☐ No If yes, what is the name? ______________________________

Name:______________________________ D.O.B:__________ Date:____________

REVIEW OF SYSTEMS – *PLEASE CIRCLE ANY SYMPTOMS YOU HAVE*:

**-Constitutional Symptoms-**
loss of appetite
excessive appetite
fatigue
difficulty sleeping
lack of exercise
night sweats

**-Endocrine Symptoms-**
feeling hot or cold
excessive thirst
excessive sweating

**-Allergic, Immunologic Symptoms-**
frequent sneezing
seasonal allergies
increased infections

**-Eyes-**
Glaucoma
blurred vision
double vision
eye pain or itching
watery eyes
cataracts

**-Ear,Nose,Throat-**
loss of hearing
earache
ringing in ears
dizziness
dental problems
sore tongue
taste changes
swelling of gums
nasal congestion
sore throat
enlarged tonsils
hoarse voice

**-Pulmonary, Respiratory Symptoms-**
chronic cough
productive cough
hemoptysis
chronic bronchitis
sleep apnea
snoring
daytime sleepiness
unrefreshed sleep

**-Cardiovascular Symptoms-**
Palpitations
Angina
swelling of feet or ankles
SOB with exertion
Sleeps on multiple pillows to breath
Heart murmur requiring antibiotic

**-Gastrointestinal-**
heart burn
difficulty swallowing
bloating
belching
nausea
frequent vomiting
vomiting blood
abdominal pain
constipation
diarrhea
black stools
pain in rectum
rectal bleeding
stool incontinence

**-Urogenital, Genitourinary-**
nighttime frequency
blood in urine
urgency
difficulty starting to urinate
burning on urination
urinary incontinence

-MEN-
painful testicles
weak urine stream
prostate problems
lumps or masses on testicles
discharge from penis

-WOMEN-
menstrual problems
breakthrough bleeding
hot flashes
lumps/mass in breast

**-Musculoskeletal Symptoms-**
joint pain from arthritis
muscle aches
back pain
joint swelling
neck pain

**Dermatology, Integumentary-**
chronic skin condition
recent rash
excessive itching
acne

**-Neurological-**
dizziness
lightheadedness
vertigo
numbness
tremor
seizures
traumatic brain injury
headache(s)
migraine(s)
impaired speech
tingling feeling
radiating pain
shooting pain
burning pain
imbalance
difficulty walking

**-Psychiatric-**
depression
difficulty making decisions
lack of concentration
memory loss
cries often
worries excessively
panic attacks
wanting psychiatric help

**-Hematologic, Lymphatic-**
diagnosis of anemia
bleeding easily
bruising easily
swelling of lymph nodes
iron deficiency