DATE: _____

Patient Name: _____ Age: _____ Date Of Birth: _____

The following information is very important to your health. Please take time to fully and completely fill out these forms. Important decisions are based on this information.

Height: _____ Weight: _____

ALLERGIES: Are you allergic to any medications (including over-the-counter drugs or iodine, tape or latex)?
Circle one: Yes No If yes, please complete the following:

Drug Allergy:	Reaction:	Other Allergy:	Reaction:
_____		_____	
_____		_____	
_____		_____	
_____		_____	

MEDICAL PROBLEMS: Please list **all** medical problems you have.

_____	_____
_____	_____
_____	_____
_____	_____

MEDICATIONS: Please list **all** medications (specify dosage and frequency) you are currently taking, including aspirin, over-the-counter medications, vitamins and herbal supplements.

_____	_____
_____	_____
_____	_____
_____	_____

Please list your PAST medications.

_____	_____
_____	_____
_____	_____

OPERATIONS: Please list **all** operations you have had.

Operation:	Date:	Operation:	Date:
_____		_____	
_____		_____	
_____		_____	
_____		_____	

SOCIAL HISTORY:
Do you use any type of tobacco product? Yes No If yes, how much per day _____
Have you EVER used any type of tobacco product? Yes No Date Quit _____
Do you drink alcohol? Yes No If yes, how often? _____
Do you use illicit drugs? Yes No If yes, please list: _____
For women: Last menstrual period: _____ Number of Pregnancies: _____ Number of Live Births: _____

Physician Signature: _____ **Date:** _____

Patient Name: _____ Date of Birth: _____

MEDICAL HISTORY: Have you been diagnosed with and/or are you currently having any of the following symptoms? Please check all that apply.

Neurologic/HEENT:
Have you had any neurological problems? Yes___ No___
___ Numbness/tingling
___ Loss of strength
___ Stroke (CVA/TIA)
___ Headaches-type _____
___ Seizures/epilepsy
___ Multiple Sclerosis
___ Ear problems
___ Eye problems
___ Nose/sinus problems
___ Throat problems

Musculoskeletal/Skin:
Have you had any muscle/bone problems? Yes___ No___
___ Back or neck problems/Joint pain
___ Loss of sensation
___ Rash/skin breakdown
___ Arthritis-type _____
___ Fractures-type _____
___ Osteoporosis

Endocrine:
Have you had any endocrine problems? Yes___ No___
___ Tired/Sluggish
___ Excessive thirst
___ Diabetes
___ Thyroid problems

Respiratory:
Have you had any breathing problems? Yes___ No___
___ Wheezing
___ Shortness of breath
___ Productive or bloody cough
___ Asthma
___ Emphysema/COPD
___ Bronchitis
___ Pneumonia
___ Sleep apnea
___ Pulmonary embolism

Cardiac:
Have you had any heart problems? Yes___ No___
___ Chest pain (Angina)
___ Palpitations/heart racing
___ Congestive heart failure
___ Heart attack
___ High blood pressure
___ Pacemaker
___ Heart valve
___ Rheumatic fever

Blood/Immune System:
Have you had any problems? Yes___ No___
___ Swollen glands
___ Anemia
___ Cirrhosis
___ DVT/phlebitis/blood clots
___ Jaundice
___ Lupus
___ Bleeding disorders
___ Scleroderma

Digestive (Stomach/Bowel):
Have you had any digestive problems Yes___ No___
___ Abdominal pain
___ Nausea/vomiting
___ Constipation
___ Diarrhea
___ Colitis
___ Diverticulitis
___ Hiatal hernia/reflux disease
___ Irritable bowel syndrome
___ Ulcers
___ Pancreatitis
___ Rectal Bleeding/rectal pain
___ Change in bowel habits
___ Hemorrhoids

Genitourinary/GYN:
Have you had any problems? Yes___ No___
___ Kidney problems/stones
___ Bladder infections
___ Kidney failure
___ Hernia
Men :
___ Prostate problems
___ Loss of sexual function
Women:
___ Uterine problems
___ Ovarian problems
___ Infertility
___ Bleeding between periods
___ Ever taken birth control pills? When:_____
___ Complications from childbirth

Constitutional:
Have you had any problems? Yes___ No___
___ Fever
___ Chills
___ Weight Loss
___ Night sweats

Communicable Diseases:
Have you had any problems? Yes___ No___
___ AIDS/HIV
___ Hepatitis A/B/C
___ Sexually transmitted disease
___ Tuberculosis

Psychologic (Emotional):
Have you had any problems? Yes___ No___
___ Nervousness
___ Anxiety
___ Depression
___ Other _____

Physician Signature: _____

Date: _____

Patient Name: _____ Date of Birth: _____

Cancer:

Have you ever been diagnosed with cancer? Yes___ No___

Type of Cancer:	Treatment:

Other:
Have you had any other medical problems not listed here?
Yes___ No___ Please list below:
_____

_____

_____

FAMILY HISTORY:

Please check which, if any, of your blood relatives had any of the following conditions:

Condition	**Parent**	**Siblings/ Children**	**Other Relatives** (Grandparents, Aunts, Uncles, Cousins, etc.)	**No Family History**	**Don't Know**
Diabetes					
Heart Disease					
Hypertension					
Gallstones					
Obesity					
Sleep Apnea					
Asthma					
Blood clots					
Cancer					
Stroke					
Kidney Disease					
Bleeding Problems					
Gout					
Allergies					
Dermatitis/Eczema					
High Cholesterol					
Osteoporosis					
Autoimmune Disease					
Psychiatric Illness					

Physician Signature: _____ **Date:** _____

*****No changes to history:**
Physician Signature:_____ **Date:** _____