Date:________________________

Name ____ Age _________ Est Weight ___________ Height __________

In brief, why are you seeing the doctor today? ____

List your allergies: ____

List your medications, including dosages: ____

____

____

Have you had any major illnesses/surgeries since your last visit? If so, explain: ____

____

Have you had any recent labs, imaging or other tests done? If so, where?: ____

____

Do you currently smoke, dip or chew, if so # per day? ___________
Have you used tobacco in the past 24 months? ________________
If you drink alcohol, # per week? ____________________________

Social/Occupational History:
Occupation _________________________________
If retired, what did you do? _________________________________
Frequently lift over: 10, 25, 50, 100 lbs (circle)
Frequently: bend, squat, crawl, climb stairs, work in dirty or unclean conditions, sweat (circle)
Do you require the assistance of: a walker, crutches, artificial limb, wheelchair, other? ___________________
Do you live alone?_____ with spouse or partner?______ with children?_____
with other? (explain) _______________________
If you live alone, do you require someone to help you with your daily driving?______ meals?_______
bathing? ________
Do you live in a nursing home or assisted care facility? _________

Who do you authorize the release of medical information to? ____
May we leave a message on your answering machine/voice-mail? Yes ______ No ______

Referring Physician: ____________________________________ Primary Physician: _____________________________________

Please note any **CURRENT PROBLEMS**:

GEN/CONSTITUTIONAL:		EYES:		EARS NOSE THROAT:		RESP:	
LOSS OF APPETITE		RECENT CHANGE IN VISION OR SURGERY		SINUS CONGESTION OR BLOCKAGE OF BREATHING		CHRONIC OR NEW COUGH OR NIGHT COUGH OR CHOKING	
DEPRESSION		BLURRED VISION		HEADACHES		ASTHMA OR WHEEZING	
WEAKNESS		EYE PAIN		NOSE BLEED		SHORTNESS OF BREATH	
WEIGHT GAIN		DIMMING OF VISION		HOARSENESS OR VOICE CHANGE		PRIOR ANESTHESIA PROBLEMS	
WEIGHT LOSS		ITCHING OR RED EYES		HEARING LOSS OR RINGING		TUBERCULOSIS	
FATIGUE		LID SWELLING		DENTURES		EMPHYSEMA OR COPD OR FREQUENT PNEUMONIA OR BRONCHITIS	
STRESS		LIGHT SENSITIVITY		DIFFICULTY SWALLOWING		COUGHING UP BLOOD	
UNABLE TO SLEEP		SEE FLASHING LIGHTS OR SPOTS		MOUTH SORES		NIGHT SWEATS	

CARDIOVASCULAR:		GASTROINTESTINAL:		HEMATOLOGIC/LYMPHATIC:	
STROKE OR CVA OR TIA		ABDOMINAL PAIN OR ACHE OR BURN OR CRAMPING		LUMPS IN THE NECK OR UNDER ARMS OR GROIN	
SEVERE CHEST PAIN OR HEART ATTACK		CONSTIPATION		BRUISE OR BLEED EASILY	
IRREGULAR HEARTBEAT OR PALPITATIONS OR VALVE PROLAPSE		DIARRHEA		ANEMIA	
VARICOSE VEINS		YELLOW JAUNDICE OR HEPATITIS LIVER CIRRHOSIS		BLEEDING PROBLEMS IN YOUR FAMILY	
SWELLING IN LEGS OR ANKLES OR FEET		VOMITING BLOOD OR PASSING BLOOD OR BLACK BOWEL MOVEMENTS		HAVE YOU HAD A BLOOD TRANSFUSION?	
LEG PAIN WITH WALKING OR FOOT/TOE PAIN AT NIGHT		NAUSEA OR VOMITING		LUPUS OR RHEUMATOID ARTHRITIS	
HIGH BLOOD PRESSURE OR TREATMENT FOR HYPERTENSION		HEARTBURN OR REGURGITATION OR BURNING IN CHEST		HEAL POORLY OR SLOWLY	
DIFFICULTY BREATHING AT NIGHT		HEMORRHOIDS		SERIOUS BLEEDING AFTER SURGERY	

ENDOCRINE:		MUSCULOSKELETAL:		SKIN:		NEUROLOGIC:	
DO YOU HAVE DIABETES?		ARTHRITIS OR JOINT PAIN		CANCER		HEADACHES OR MIGRAINES	
LOW BLOOD SUGAR OR PASS OUT EASILY		FIBROMYALGIA OR MUSCLE TENDERNESS OR ACHE		EASY BRUISING		PRIOR CONCUSSION	
LOW THYROID		BACK PAIN OR PAIN INTO BUTTOCKS OR LEGS		COLOR CHANGE		VERY PAINFUL/SENSITIVE AREAS ON BODY TO TOUCH OR PRESSURE	
HIGH THYROID		CRAMPS IN BUTTOCK OR THIGH OR ARM OR CALF		ITCHING		CONVULSIONS OR SEIZURES OR EPILEPSY	
HOT FLUSHES WITH WEAKNESS		MAJOR INJURIES OR SURGERY		NEW DARK MOLES		EASY FAINTING OR BLACKOUTS	
COLD INTOLERANCE		NECK INJURIES OR SURGERY		SCARS TEND TO BE UGLY		PERIODS OF MEMORY LOSS	
REALLY SEVERE EXPLAINED HEADACHE		NEED CRUTCH OR WALKER OR WHEEL CHAIR		TATTOOS		BALANCE PROBLEMS OR FREQUENT FALLS	
UNEXPLAINED PERIOD OF SEVERE WEAKNESS		FRACTURES OR BROKEN BONES		RASHES/IRRITATION/REDNESS OR CRACKING SKIN OR NAIL		VERY WEAK OR PARALYZED PARTS OF YOUR BODY	

PSYCHIATRIC:		BREASTS:		GENITOURINARY MALE:		GENITOURINARY FEMALE:	
LOTS OF INAPPROPRIATE ANXIETY OR FEAR		BREAST PAIN		PAINFUL OR DIFFICULT URINATION		DELIVERED CHILDREN	
UNREASONABLE ANGER AND LOSS OF CONTROL		SWELLING		PAINFUL INTERCOURSE OR IMPOTENCE		BLOOD IN URINE OR VAGINA	
DEPRESSION OR LOSS OF INTEREST		LUMPS OR NODULES		UP TO PASS WATER MORE THAN ONCE AT NIGHT		PAINFUL MENSTRUATION	
SLEEP PROBLEMS		NIPPLE DISCHARGE		LOSING URINE WITH COUGH/SNEEZING OR INVOLUNTARILY		LOSING URINE WITH COUGH/ SNEEZING OR INVOLUNTARILY	
UNEXPLAINED FATIGUE		SURGERY OR BIOPSY		ABNORMAL DRAINAGE, HERPES OR SYPHILIS OR GONORRHEA		BLADDER OR KIDNEY INFECTION	
VOICES IN HEAD OR HALLUCINATIONS OR SUICIDAL THOUGHTS		FAMILY HISTORY OF BREAST CANCER OR OVARIAN CANCER		KIDNEY STONES		GONORRHEA OR SYPHILIS OR CHLAMYDIA OR HERPES	
CONCERNED THAT YOU ARE LOSING CONTROL		ABNORMAL MAMMOGRAM OR ULTRASOUND		A BLOODY OR BROWN OR SMOKY URINE		PELVIC INFECTIONS	
ALCOHOL OR OTHER DRUG/MEDICATION ABUSE.		FIBROCYSTIC DISEASE		KIDNEY OR BLADDER OR PROSTATE INFECTIONS		URINARY STONES	

I certify that the above information is correct to the best of my knowledge. I will not hold my doctor or any members of his/her staff responsible for any errors or omissions that I may have made in the completion of this form.

____ ____________

Signature Date