PATIENT INFORMATION

Please fill this form out in its entirety before you come into the office.

Name:				Date:		Date of Birth:	
Phone to contact for any results:		Cell:		Home:		Work:	
What Pharmacy do you use?		Address:				Phone:	

REVIEW OF SYSTEMS

Have you recently experienced any of the following (or similar) symptoms? If so, please check and give details below.

Yes	No	
		1. General: change in weight, change in appetite, chills, fever, night sweats, fatigue, lethargy, persistent infections, tiredness
		2. Skin: brittle nails, bruising, change in mole/wart, change in skin color, hair loss, hives, itching, skin rash, sore or wound that won't heal
		3. Head, Eyes, Ears, Nose, and Throat: bleeding gums, blurry vision, difficulty swallowing, dizziness, double vision, dry eyes, ear infection or discharge, ear pain, eye pain, headache, hay fever or post nasal drainage, hearing difficulty, hoarseness, itchy or watery eyes, ringing in ears, sinus trouble, sore throat, sore tongue or mouth
		4. Neck: difficulty swallowing, pain, stiffness, swollen glands
		5. Respiratory: congestion, coughing, coughing up blood, shortness of breath, snoring, sputum, wheezing
		6. Breast: lump, nipple discharge, nipple pain, recent size change, swelling
		7. Cardiovascular: ankle swelling, chest pain, fainting, high blood pressure, light headedness, palpitations, shortness of breath
		8. Gastrointestinal: abdominal pain, black bowel movement, blood in bowel movement, change in bowel pattern, constipation, diarrhea, excessive gas, heartburn, indigestion, nausea, vomiting
		9. Genitourinary: abnormal color in urine, absence of menstruation, blood in urine, change in urinary stream, excessive menstrual bleeding, excessive non-menstrual bleeding, foul odor to urine, frequent urination, hot flashes, incontinence, menstrual irregularities, painful intercourse, painful menstruation, painful urination, sexual dysfunction, straining urination, testicular mass, testicular pain, urine leakage, vaginal bleeding, vaginal itching
		10. Musculoskeletal: back pain, decreased range of motion, loss of strength, muscle aches, painful joints, stiffness, swollen joints
		11. Neurological: dizziness, easily distracted, headaches, memory loss, numbness, seizures, spinning sensation, trouble walking
		12. Psychiatric: anxiety, change in sleep pattern, depression, insomnia, mood swings
		13. Endocrine: cold intolerance, excessive thirst, heat intolerance, sweating
		14. Hematology: abnormal bleeding, easy bruising, nosebleeds

Details: Please reference using the numbers above.

HISTORY

Past Medical: List any chronic medical conditions you have (ex. Diabetes, Hypertension, Asthma, Thyroid Disorder, etc.).

Allergies: List all allergies and the reaction they cause

Immunizations: Enter dates, if known.

□ Smallpox	□ Measles [MMR]	□ Hepatitis A	□ Hepatitis B	□ Polio	□ Typhoid
□ Pneumonia	□ Gardasil	□ Shingles	□ Tetanus	□ Meningitis	

Family Members

	Living/# Living	Age/Age at Death	Present Health, Chronic Conditions and/or Cause of Death
Father			
Mother			
Spouse			
Brother(s)			
Sister(s)			
Children			

Social:

□ Alcohol	How much/day:		□ Tobacco	How much/day:		□ Caffeine	How much/day:	
□ Sleep	How much/night:		□ Drug Use	How much/day:		What drugs:		
□ Exercise	How often:			Activities:				

Medication: List any medications you currently take on a daily basis including dosage and frequency.

Reproductive: Women Only

List the outcome of each pregnancy:			
Date of last Pap Smear:		Date of last Mammogram:	

Past Surgical: List any surgical procedure you have ever had, including year of procedure

Past Diagnostic Studies: Have you ever had and when.

Any CT Scans:		Any MRI Scans:	
Stress Testing:		Other Cardiac Test:	
Endoscopies:		Ultrasound:	

Health Maintenance: Have you ever had and when.

Eye Exam:		Dental Exam:	
Colonoscopy:		Bone Density:	
Prostate Check:			