

Patient Name: _____ Date _____

Please Review and indicate any medical issues you may have:

Do you suffer from: fever, weight loss, trouble sleeping? Describe: _____

Eyes: (e.g. Double vision, Blurring, Trauma, Glasses) Describe: _____

Ear, nose and throat (e.g. Deafness, Sinusitis, Hoarseness, Dizziness) Describe: _____

Cardiovascular (e.g. Chest pain, Palpitations, Hypertension ; irregular beats)
Describe: _____

Respiratory (e.g. Shortness of breath, Asthma, COPD, Cough, Coughing up Blood)
Describe: _____

GI (e.g. Appetite, Weight change, Diarrhea, Constipation, Abdominal pain) Describe: _____

GU (e.g. Hesitancy, Incontinence, Painful urination, Menstrual history, Pregnancies) Describe: _____

Musculoskeletal/Orthopedic (e.g. Fracture, Sprains, Pain, Swelling, Arthritis, Stiffness,) Describe: _____

Skin/Breast (e.g. Color, Temp, Rashes, Lesions, Scars, Masses, Ulcers) Describe: _____

Neuro (e.g. Speech and swallowing, Stroke, Tingling, Changes in sensation, Seizures, Weakness, Visual changes, Balance, Memory, Coordination problems)
Describe: _____

Psychiatric (e.g. Depression, Moodiness, Hallucinations, Sleep disturbances) Describe: _____

Blood/Lymphatic (e.g. Bleeding tendency, Lymph node pain/enlargement , Anemia).
Describe: _____

Skin Allergy (e.g. Dermatitis, Eczema, Urticaria, Latex, Drug & Other Allergies)
Describe: _____

Please Review for your Family History:

Parents ages and health (if deceased, age at death and cause)
Describe _____

Siblings sex, ages and health (if deceased, age at death and cause)
Describe _____

Family History: Arthritis– Y/N ; Hypertension – Y/N; Heart disease Y/N ; Endocrine disease Y/N ;
Muscular disease Y/N ; Diabetes - Y/N

Social History:

Single/Married/Divorced/Partner Children Y/N Ages _____

Alcohol use(amount & type) _____ Non-prescription drug use(amount & type) _____

Tobacco use _____ppd X _____years