Name_____Today's Date_____SS#_____Date of Birth_____

Primary Care Doctor:_____Reason for Visit?_____

Current problem is the result of (check all that apply): ____Work accident ____auto accident ____Other (describe)

DO YOU HAVE ANY ALLERGIES? ___No ___Yes (List please):

CURRENT MEDICATIONS Please complete or provide Printed List to Staff

Medication_____Dose_____Frequency_____ How long on Med?_____

Medication_____Dose_____Frequency_____How long on Med?_____

Medication_____Dose_____Frequency_____How long on Med?_____

Over The Counter Medications, Vitamins or Herbal Preparations:_____

TOBACCO USE: (circle) Current Former Never Type:_____

SOCIAL HISTORY
__Employed (occupation)_____ __Student __Work in home
Marital Status: __Single __Married __Divorced __Separated __Widowed
Children? __No __Yes (ages:)

Are you on a special diet? __No __Yes (please explain):
Do you have a history of substance abuse? __No __Yes (please explain):
Do you drink alcohol? __No __daily __1-2x/week __1-2x/month

PAST MEDICAL HISTORY
Please list any hospitalizations or surgery and dates:

_____
_____
_____
_____
_____

REVIEW OF SYSTEMS Please Circle All that Apply:
GENERAL: Weight loss, Fevers, Chills, Sweats
HEENT: Dry eyes, Red eyes, Sore throat, Dental problems
PULMONARY: Shortness of breath, Wheezing, Productive cough, Coughing up blood
CARDIOLOGY: Chest pain, Irregular heartbeats, Leg swelling
GI: Nausea, Vomiting, Diarrhea, Constipation, Heartburn, Abdominal pain
GU: Blood in urine, Unusual menstrual bleeding, Burning with urination, Discharge
NEUROLOGY: Headache, Dizziness, Balance, Numbness, Tingling, Weakness, Bowel/Bladder Dysfunction
MUSCULOSKELETAL: Joint stiffness, Swollen joints, Warm/red joints, Neck pain, Back pain, Arthritis
HEMATOLOGY: Bruising, Bleeding, Family history bleeding/clotting problems
ENDOCRINE: Skin changes, Hair changes, Heat/cold intolerance, Poor healing
SKIN: Rashes, Wounds
ALLERGY: Medication allergies, Material allergies, Swollen glands, Allergy to Bees
PSYCHOLOGY: Anxiety, Depression

FAMILY HISTORY: Mother: Alive/Deceased (cause) Father: Alive/Deceased (cause) Sister/Brother: Alive/Deceased (cause) *Please describe any pertinent family medical history: