



Established in 1973

Patient History

Patient Name: _____

Age: _____ Date _____ Date of Birth _____

Height _____ Weight _____

Describe your problem or injury: _____

Date of onset of the problem: _____

Name of Primary Care Physician: _____

Other Physicians you are currently seeing: _____

Past Medical History

Previous Operations: (Please list surgery, approximate date of surgery, name of surgeon and hospital where performed):

Previous Major Illnesses & Non-Surgical Hospitalizations: _____

(Please check if you are currently receiving treatment or have received treatment in the past for any of the following conditions)

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Birth Defects |
| <input type="checkbox"/> Bleeding Disorders | <input type="checkbox"/> Cancer | <input type="checkbox"/> Currently Pregnant | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Heart Disease(s) | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Intestinal Disorders |
| <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Phlebitis (blood clots) | <input type="checkbox"/> Recurrent Infections | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Sexually Transmitted Diseases | <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Disease |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Other (Please Specify) _____ | | |

Medications

Are you taking any prescription or over the counter medications? Yes No

If yes, please list medications, dosage, how long you have been taking and the name of the prescribing physician:

Drug Allergies: (Please list any drugs/substances to which you have had a reaction, and describe the reaction):

Review of Systems

(Please describe which of the following symptoms you have experienced regularly in the past)

GENERAL:	<input type="checkbox"/> Fever	<input type="checkbox"/> Night sweats	<input type="checkbox"/> Weight loss	<input type="checkbox"/> Daytime sleepiness
EYES:	<input type="checkbox"/> Blurring	<input type="checkbox"/> Eyestrain	<input type="checkbox"/> Glasses/contacts	<input type="checkbox"/> Discharge
THROAT:	<input type="checkbox"/> Soreness	<input type="checkbox"/> Hoarseness	<input type="checkbox"/> Difficulty swallowing	
GASTROINTESTINAL:	<input type="checkbox"/> Nausea	<input type="checkbox"/> Vomiting	<input type="checkbox"/> Belching/Indigestion	<input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn/reflux
SKIN:	<input type="checkbox"/> Eruptions/rashes	<input type="checkbox"/> Cyanosis	<input type="checkbox"/> Jaundice (yellow tint)	
EARS:	<input type="checkbox"/> Deafness	<input type="checkbox"/> Ringing in ears	<input type="checkbox"/> Pain	<input type="checkbox"/> Discharge
GENITOURINARY:	<input type="checkbox"/> Pain	<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Incontinence	<input type="checkbox"/> Urination at night
MUSCULOSKELETAL:	<input type="checkbox"/> Weakness	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Tingling	<input type="checkbox"/> Low back pain <input type="checkbox"/> Deformities
HEAD:	<input type="checkbox"/> Headache	<input type="checkbox"/> Dizziness/blackouts	<input type="checkbox"/> Trauma	
NOSE:	<input type="checkbox"/> Sinusitis	<input type="checkbox"/> Obstruction		
RESPIRATORY:	<input type="checkbox"/> Asthma	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Bloody sputum	<input type="checkbox"/> Date last chest x-ray: _____
CARDIOVASCULAR:	<input type="checkbox"/> Chest pain	<input type="checkbox"/> Faintness	<input type="checkbox"/> Varicose veins	<input type="checkbox"/> Rapid or throbbing heartbeat
	<input type="checkbox"/> Fluid/swelling around extremities		<input type="checkbox"/> Pain in legs when walking	

FEMALE REPRODUCTIVE

Number of pregnancies: _____ Number of deliveries: _____
 Date of last routine exam: _____ Date last menstrual period: _____
 Date of last mammogram: _____ Periods regular? _____

Family History

(Have mother, father, grandparents, brothers, sisters been treated in the past or currently receiving treatment for any of the following conditions?)

- Arthritis Cancer Diabetes Heart Disease
 High Blood Pressure Kidney Disease Other (Please Specify) _____

Please list health status or cause of death for the following family members:

Mother: _____
 Father: _____
 Siblings: _____
 Children: _____

Social History

Marital Status: Single Married Other

Occupation: _____ Full Time Part Time Student

Next of Kin: _____ Telephone: _____

Do you now or have you previously used tobacco products? Yes No

If yes, products and amount per day _____ Duration _____

Do you consume alcohol products? Yes No If yes, amount & frequency: _____

Patient Signature: _____ Date: _____