Your Name: _____ Date of Birth: _____ Chart # _____

Please List your Allergies:

Today's Date: _____ _____

Do you have a history of:

	YES	NO		YES	NO
High Blood Pressure	☐	☐	Heart Disease	☐	☐
Heart Attack	☐	☐	Stroke	☐	☐
Thyroid Disease	☐	☐	Lung Disease	☐	☐
Asthma	☐	☐	Tuberculosis	☐	☐
Stomach Ulcers	☐	☐	Diabetes	☐	☐
Digestive Disorders	☐	☐	Liver Disease	☐	☐
Kidney Disease	☐	☐	Prostate Disease	☐	☐
Seizure Disorder	☐	☐	Depression	☐	☐
Arthritis	☐	☐	Cancer	☐	☐

Do you smoke? Y N
When did you start? _____ Quit? When_____

Please Check or List any Surgeries and their Dates:

__ Tonsillectomy _____
__ Hernia Repair _____
__ Appendectomy _____
__ Hysterectomy _____
__ Heart Surgery _____
__ Gall Bladder Removed _____
__ Back/Spine Surgery _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

Family History: Have any close blood relatives had (please circle)

Heart Attacks
Colon Cancer
Diabetes
Depression
High Blood Pressure
Breast Cancer
Emphysema
High Cholesterol
Other Cancer
Osteoporosis

Please List All Medications you take:

Please check off any of the following symptoms or problems you have had:

GENERAL
__ Chills
__ Depression
__ Dizziness/Fainting
__ Forgetfulness
__ Headache
__ Loss of sleep
__ Loss of weight
__ Nervousness
__ Numbness
__ Sweats

MUSCLE / JOINT / BONE
Pain, weakness, numbness in:
__ Arms __ Hips
__ Back __ Legs
__ Feet __ Neck
__ Hands
__ Shoulders

BLADDER / URINARY
__ Blood in urine
__ Frequent urination
__ Lack of bladder control
__ Painful urination

SKIN
__ Bruise easily
__ Hives
__ Itching
__ Change in moles
__ Rash

STOMACH / BOWELS
__ Appetite poor
__ Bloating
__ Bowel changes
__ Constipation
__ Diarrhea
__ Dark Black Stools
__ Excessive thirst
__ Gas
__ Hemorrhoids
__ Indigestion
__ Nausea
__ Rectal bleeding
__ Stomach pain
__ Vomiting
__ Vomiting blood

Are you on a diet? Y N

Do you drink alcohol? Y N
(beer/wine/liquor)
<1/week, 1-5/wk, >6/week
Please Circle

HEART / LUNGS / CIRCULATION
__ Chest pain
__ Shortness of Breath
__ High blood pressure
__ Irregular heart beat
__ Low blood pressure
__ Poor circulation
__ Rapid heart beat
__ Swelling of ankles
__ Varicose veins

EYE, EAR, NOSE, THROAT
__ Bleeding gums
__ Blurred vision
__ Crossed eyes
__ Difficulty swallowing
__ Double vision
__ Earache
__ Ear discharge
__ Hay fever
__ Hoarseness
__ Itchy or Red Eyes
__ Loss of hearing
__ Nosebleeds
__ Persistent cough
__ Ringing in ears
__ Sinus problems
__ Vision - Flashes/Halos

MEN only
__ Breast lump
__ Erection difficulties
__ Lump in testicles
__ Penis discharge
__ Sore on penis
__ Other

WOMEN only
__ Abnormal Pap Smear
__ Bleeding between periods
__ Breast lump
__ Extreme menstrual pain
__ Hot flashes
__ Nipple discharge
__ Painful intercourse
__ Vaginal discharge
__ Other

Date of last menstrual period _____
Date of last Pap Smear: _____
Have you had a mammogram? Y N
Date of Last: _____
Are you pregnant? Y N
Number of Pregnancies _____
Number of children_____
Did you breastfeed Y N