Patient Information

Name	Date
Address	
Home Phone	Alternate Phone
E-Mail	
Date of Birth	Age
Occupation	
Referred by	

Emergency Contact Information

Name	Relation
Home Phone	Alternate Phone

Other Health Care Providers

Name	Occupation	Phone
Name	Occupation	Phone
Name	Occupation	Phone
Name	Occupation	Phone
Name	Occupation	Phone

Medical Concerns

List your primary health concerns, in order of importance. Please describe their onset, how long you have been experiencing them, and any other useful information in the space provided below.

1.
2.
3.
4.
5.

Medical History

Please list any serious conditions, illnesses, injuries, and hospitalizations below, along with their approximate dates.

Date	*Condition, illness, injury, or hospitalization*

How would you rate your current health? Excellent ◯ Good ◯ Fair ◯ Poor ◯

Do you get regular screening done by another doctor? Yes ◯ No ◯

If you have any allergies please list them below.

List all medications you are currently taking.

Name	*Dose*	*Reason*

List all supplements you are currently taking.

Name	*Dose*	*Reason*

List all past prescription medications you have taken.

Name	*Dose*	*Reason*

Do you frequently take any of the following products?

Aspirin ☐ *Tylenol* ☐ *Advil* ☐ *Robaxacet* ☐
Laxatives ☐ *Antacids* ☐ *Cough remedies* ☐ *Asthma Inhaler* ☐
Diet Pills ☐ *Birth Control Pills* ☐

How much *alcohol* do you consume per week?

How much *tobacco* do you consume per week?

How much *caffeine* do you consume per week?

Do you use *recreational drugs*? What type and how often?

Did you use *recreational drugs* in the past?

Please list the five most significant, stressful events in your life, from the most recent to the most distant. Do any of these events still affect your life now? Please explain.

1.
2.
3.
4.
5.

Dietary Factors

Describe a typical day's food and beverage intake:

Breakfast

Lunch

Dinner

Snacks

Beverages

Do you have any dietary restrictions or sensitivities?

Family History

Indicate which of your close relatives suffers from any of the following conditions:

Allergies

Asthma

Cancer (list type)

Depression

Diabetes

Digestive issues

Heart disease

High blood pressure

High cholesterol

Kidney disease

Mental illness

Substance abuse

Other (please list)

Environmental Factors

Where do you work?

What are your hobbies?

Are you regularly exposed to animals?

Are you regularly exposed to chemicals?

Are you regularly exposed to smoke?

Describe your home environment

Please describe anything that you feel is important and has not been covered.

Review of Systems

Mark the relevant conditions listed below. Mark '*Yes*' when a condition that you currently experience is listed. Mark '*Past*' when a condition is listed that you have suffered from at anytime in your past. Please comment on any condition when you feel it is pertinent.

Current weight			
Weight 1 year ago			
Maximum weight			
Height			
	Yes	***Past***	***Comments***
Fatigue/weakness	☐	☐	
Fever/chills	☐	☐	
Skin			
Rashes	☐	☐	
Eczema	☐	☐	
Hives	☐	☐	
Acne (more than mild)	☐	☐	
Boils	☐	☐	
Itching	☐	☐	
Color change	☐	☐	
Lumps	☐	☐	
Night sweats	☐	☐	
Dry	☐	☐	
Moist	☐	☐	
Cold to the touch	☐	☐	
Hot to the touch	☐	☐	
Nail changes	☐	☐	
Change in Mole	☐	☐	
Skin Cancer	☐	☐	
Head			
Headache	☐	☐	
Head injury	☐	☐	
Dizziness	☐	☐	
Eyes			
Impaired vision	☐	☐	
Glasses/Contacts	☐	☐	
Eye pain	☐	☐	
Tearing	☐	☐	
Dry	☐	☐	
Double vision	☐	☐	
Glaucoma	☐	☐	
Cataracts	☐	☐	

	Yes	*Past*	*Comments*
Blurring	☐	☐	
Sensitive to the sun	☐	☐	
Itching	☐	☐	
Redness	☐	☐	
Discharge	☐	☐	
Blind spot	☐	☐	
Ears			
Impaired hearing	☐	☐	
Earache	☐	☐	
Dizziness	☐	☐	
Vertigo	☐	☐	
Discharge	☐	☐	
Infections	☐	☐	
Nose & Sinuses			
Frequent colds	☐	☐	
Nose bleeds	☐	☐	
Stuffiness	☐	☐	
Hay fever	☐	☐	
Sinus problems	☐	☐	
Mouth & Throat			
Frequent sore throat	☐	☐	
Sore tongue/mouth	☐	☐	
Gum problems	☐	☐	
Hoarseness	☐	☐	
Cavities	☐	☐	
Loss of taste	☐	☐	
Neck	☐	☐	
Lumps	☐	☐	
Swollen glands	☐	☐	
Goiter	☐	☐	
Pain	☐	☐	
Stiffness	☐	☐	
Respiratory (lungs)			
Chronic cough	☐	☐	
Cough up mucous	☐	☐	
Cough up blood	☐	☐	
Wheezing	☐	☐	
Asthma	☐	☐	
Bronchitis	☐	☐	
Pneumonia	☐	☐	
Pleurisy	☐	☐	
Emphysema	☐	☐	
Difficulty breathing	☐	☐	
Pain on breathing	☐	☐	
Shortness of breath	☐	☐	
Short of breath at night	☐	☐	
Short of breath lying down	☐	☐	
Tuberculosis	☐	☐	

	Yes	*Past*	*Comments*
Tuberculin Test	☐	☐	
Chest X-ray	☐	☐	
Cardiovascular (heart)			
Heart disease	☐	☐	
Angina	☐	☐	
High blood pressure	☐	☐	
Murmurs	☐	☐	
Rheumatic fever	☐	☐	
Chest pain	☐	☐	
Palpitations/fluttering	☐	☐	
Cyanosis	☐	☐	
Swelling in ankles	☐	☐	
Heart attack	☐	☐	
Stroke	☐	☐	
Past ECG/EKG	☐	☐	
Other heart tests	☐	☐	
Breasts			
Monthly self exam	☐	☐	
Lumps	☐	☐	
Pain/tenderness	☐	☐	
Fibrocystic breasts	☐	☐	
Nipple discharge	☐	☐	
Breast cancer	☐	☐	
Abdomen & Gastrointestinal			
Trouble swallowing	☐	☐	
Heartburn	☐	☐	
Change in thirst	☐	☐	
Change in appetite	☐	☐	
Nausea	☐	☐	
Chronic vomiting	☐	☐	
Vomiting blood	☐	☐	
How often do you have a bowel movement?			
Is this a change?			
Blood in stool	☐	☐	
Excessive belching or gas	☐	☐	
Jaundice (yellow skin/eyes)	☐	☐	
Liver disease	☐	☐	
Gallbladder disease	☐	☐	
Ulcer	☐	☐	
Indigestion	☐	☐	
Diarrhea	☐	☐	
Rectal bleeding	☐	☐	
Hemorrhoids	☐	☐	
Black, tarry stool	☐	☐	
Unexplained abdominal pain	☐	☐	
Hernias	☐	☐	
Urinary			
Pain on urination	☐	☐	

	Yes	*Past*	*Comments*
Increased frequency	☐	☐	
Frequency at night	☐	☐	
Inability to hold urine	☐	☐	
Frequent infections	☐	☐	
Kidney stones	☐	☐	
Blood in urine	☐	☐	
Urgency	☐	☐	
Hesitancy	☐	☐	
Male Reproductive			
Hernia	☐	☐	
Testicular mass	☐	☐	
Testicular pain	☐	☐	
Enlarged prostate	☐	☐	
Female Reproductive			
Age menses began			
Average length of menses (include spotting)			
Length of cycle (day 1 to day 1)			
Last menstrual period (day 1)			
Regular cycles	☐	☐	
Bleeding between periods	☐	☐	
Painful menses	☐	☐	
Excessive flow	☐	☐	
PMS	☐	☐	
Pain during intercourse	☐	☐	
Vaginal discharge	☐	☐	
Vaginal itching	☐	☐	
Fibroids	☐	☐	
Difficulty conceiving	☐	☐	
Number of pregnancies			
Number of live births			
Number of miscarriages			
Number of abortions			
Date of last PAP			
Sexual Health			
Are you sexually active?	☐	☐	
Sexual difficulties	☐	☐	
Venereal disease	☐	☐	
Genital sores	☐	☐	
Genital rash	☐	☐	
Sexual preference			
Musculoskeletal			
Joint pain	☐	☐	
Joint stiffness	☐	☐	
Joint swelling	☐	☐	
Arthritis	☐	☐	
Broken bones	☐	☐	
Muscle spasms or cramps	☐	☐	
Weakness	☐	☐	

	Yes	*Past*	*Comments*
Backache	☐	☐	
Peripheral Vascular			
Deep leg pain	☐	☐	
Excessively cold hands/feet	☐	☐	
Varicose veins	☐	☐	
Inflamed/painful veins	☐	☐	
Leg cramps	☐	☐	
Extremity numbness	☐	☐	
Extremity swelling	☐	☐	
Extremity ulcers	☐	☐	
Neurologic			
Fainting	☐	☐	
Involuntary movement	☐	☐	
Seizures/Convulsions	☐	☐	
Paralysis	☐	☐	
Muscle weakness	☐	☐	
Numbness or tingling	☐	☐	
Loss of memory	☐	☐	
Loss of balance	☐	☐	
Speech problems	☐	☐	
Endocrine			
Heat intolerance	☐	☐	
Cold intolerance	☐	☐	
Thyroid trouble	☐	☐	
Excessive thirst	☐	☐	
Excessive hunger	☐	☐	
Excessive urination	☐	☐	
Excessive sweating	☐	☐	
Diabetes	☐	☐	
Hypoglycemia	☐	☐	
Hyperglycemia	☐	☐	
Hormone therapy	☐	☐	
Blood & Lymphatic			
Anemia	☐	☐	
Easy bleeding or bruising	☐	☐	
Past transfusions	☐	☐	
Swollen lymph nodes	☐	☐	
Emotional			
Depression	☐	☐	
Mood swings	☐	☐	
Anxiety or nervousness	☐	☐	
Tension	☐	☐	
Phobias	☐	☐	
Insomnia	☐	☐	
How many hours do you sleep each night?			
How many hours of television per day?			
Do you enjoy your work?			