Patient Name:_____ **Today's Date:**_____

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

Medical:

____ No Medical History

HIV/AIDS

Allergies

Chronic Seasonal

Alzheimer's

Anemia

Arthritis / Rheumatoid

Cancer: _____

Chest Pains

COPD

Dementia

Diabetes

Type 1 Type 2 Gestational

Family History of Diabetes

Heart Attack

Heart Condition: _____

Heart Disease

Hepatitis: A B C

Herpes Virus

Cold Sores Shingles

High Cholesterol

High Blood Pressure

Kidney Problems

Dialysis Disease Failure

Liver Disease

Long Term/ Current Steroid Use

Lupus

Melanoma

Meningitis

Migraine

Multiple Sclerosis

Pneumonia

Pregnant

Psychiatric Disorder

Recent Chemotherapy Treatment

Recent fall

Radiotherapy Treatment

Seizures

Sickle Cell

Sleep Apnea

Stroke

Syphilis

Temporal Arteritis

Terminal Illness: _____

TIA (Transient Ischemic Attack)

TB

Thyroid Disease

Surgical:

___ No Surgical History *(please list dates)*

Amputation

Angioplasty

Back Surgery

Blood Transfusion

CABG

Defibrillator

Gastric Bypass

Heart Bypass

Heart Stent

Mastectomy

Pacemaker

Thyroidectomy

Transplant:

Head Trauma: ***Date:***_____ _____

Ocular Trauma: ***Date:***_____

Other Trauma: ***Date:***_____

SOCIAL HISTORY:

SMOKING STATUS
DAILY OCCASIONAL FORMER NEVER

ALCOHOL STATUS:
DAILY OCCASIONAL FORMER NEVER

STREET DRUGS:
NO YES:_____

DO YOU LIVE ALONE?
YES NO

DO YOU DRIVE?
YES NO

Please list ALL of your current medications, or provide front office with an updated list

Name/dose/frequency/route

_____

_____

_____

_____

_____

_____

_____

_____

<u>FAMILY HISTORY:</u>
DIABETES
Mother Father Child Sibling Grandparent

CANCER
Mother Father Child Sibling Grandparent

STROKE
Mother Father Child Sibling Grandparent

HEART DISEASE
Mother Father Child Sibling Grandparent

GLAUCOMA
Mother Father Child Sibling Grandparent

MACULAR DEGENERATION
Mother Father Child Sibling Grandparent

RETINAL DETACHMENT
Mother Father Child Sibling Grandparent

CATARACTS
Mother Father Child Sibling Grandparent

ARTHRITIS
Mother Father Child Sibling Grandparent

HIGH BLOOD PRESSURE
Mother Father Child Sibling Grandparent

KIDNEY DIESEASE
Mother Father Child Sibling Grandparent

THYROID DISEASE
Mother Father Child Sibling Grandparent

Please list your allergies if any:

_____

_____

<u>REVIEW OF SYSTEMS:</u>

♦ALLERGY:

None

Patient Name:_____ **Today's Date:**_____

PLEASE CIRCLE WHICH OF THE FOLLOWING APPLY TO YOU. YOU MAY CIRCLE MORE THAN ONE

Autoimmune
Seasonal

♦CARDIOVASCULAR:
None
Chest Pain
Shortness of Breath
Irregular Heart Beat/ Heart Palpitations
Blood Pressure Stable
Blood Pressure Uncontrolled
Unsure of Blood Pressure Control
Swelling of Extremities

♦CONSTITUTIONAL:
None
Intolerance to cold/heat
Hair Loss
Nervousness
Fever Chills
Weight Loss Loss of Appetite
Fatigue
Feels Sick/ Weak

♦ENDOCRINE:
None
Excessive Thirst
Excessive Urination
Intolerance of Cold/Heat
Hair Loss
Unsure of Blood Sugar Control
Sarcoidosis
Swollen Lymph Nodes

♦GASTROINTESTINAL:
None
Abdominal Pain
Nausea Vomiting Diarrhea
Bloody Stool
Stomach Ulcer
Trouble Swallowing

♦GENITOURINARY:
None
Bladder Trouble: _____
Kidney Stones

♦HEMATOLOGY/ONCOLOGY:
None
Easy Bruising
Prolonged Bleeding
Swollen Lymph Nodes

♦HEAD/EARS/NOSE/THROAT:
None
Hearing Loss
Sore Throat
Runny Nose
Dry Mouth
Jaw Claudication
Ear Ache
Stiff Neck

♦SKIN and BREAST
None
Rash

Change in Mole
Skin Sores
Nail Changes

♦MUSCULOSKELETAL:
None
Muscle Aches
Joint Pain
Back Pain

♦NERUOLOGIC:
None
Weakness
Headaches
Scalp Tenderness
Dizziness
Paralysis of Extremities
Tremor
Stroke
Numbness
Seizures or Convulsions
Fainting

♦PSYCHIATRIC:
None
ADHD
Bipolar Disorder
Depression Anxiety
Panic Attack

♦RESPIRATORY:
None
Wheezing
Coughing Up Blood
Severe or Frequent Colds
Difficulty Breathing

Please list any other issues you think we may need to know:

_____
_____
_____
_____
_____
_____
_____

THANK YOU FOR YOUR HELP. FILLING OUT THIS INFORMATION WILL HELP US SPEED UP THE TIME OF YOUR VISIT!