

Date: \_\_\_\_\_

MRN# \_\_\_\_\_

**Confidential record: Information contained here will not be released except when you have authorized us to do so.**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_  
Address \_\_\_\_\_ City, State, Zip \_\_\_\_\_  
Birthdate \_\_\_\_\_ Birth place \_\_\_\_\_  
Home Phone \_\_\_\_\_ Cell Phone \_\_\_\_\_  
Family or Referring Physician \_\_\_\_\_ Physician Office# \_\_\_\_\_  
Physician Fax# \_\_\_\_\_ Physician Address \_\_\_\_\_

**REASON FOR HEALTH VISIT:**

What symptoms or medical problem are you seeing Doctor today for:

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**MEDICAL PROBLEMS:**

List all current medical problems and those that have required hospitalization in the past:

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**SURGICAL HISTORY:**

Please list all previous surgeries:

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**MEDICATIONS:** Please list all medications, dosages, and frequency of administration:

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**NAME ANY DRUGS TO WHICH YOU ARE ALLERGIC:**

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***PLEASE CIRCLE IF YOU HAVE ANY OF THE BELOW SYMPTOMS:***

**Constitutional** – fever, weight loss, weight gain, night sweats, nausea

**Eyes** – blurred vision, dry eyes, double vision, loss of vision, pain with eye movement

**Cardiovascular** – heart disease, chest pain, palpitations, swelling of the feet and legs

**Respiratory** – asthma, COPD, difficulty breathing, shortness of breath

**Gastrointestinal** – abdominal pain, diarrhea, constipation, bloody stools

**Genitourinary** – painful urination, blood in the urine, frequent urination, sexual dysfunction

**Musculoskeletal** – joint pain, muscle pain

**Skin** – rashes, bites

**Neurological** – seizures, headaches, dizziness, falls, incoordination, numbness, tingling, back pain, neck pain, weakness, difficulty walking, stroke

**Psychiatric** – depression, anxiety, mood disorders

**Endocrine** – intolerant to heat, cold, thyroid dysfunction

**Hematologic** – easy bruising, bleeding, history of blood transfusions

**Allergy** - seasonal or environmental allergies

**Infectious** - HIV, Hepatitis A B C

Patient Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_

Date: \_\_\_\_\_

