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:

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

SURGICAL HISTORY:
Please list all previous surgeries:

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

NAME ANY DRUGS TO WHICH YOU ARE ALLERGIC:

PERSONAL HISTORY:

Occupation:_____

Do you smoke?: Yes No

If so how much?:_____

Have you ever smoked? Yes No

How much alcohol do you drink?_____

Any history of recreational drug use? Yes No

If so which drugs?:_____

FAMILY HISTORY:

	Age	Medical Problems	Deceased- if so from what cause?
Father			
Mother			
Brothers/Sisters:			

PLEASE <u>CIRCLE</u> 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:_____