MEDICAL HISTORY

Name:		**Date:**	**Which hand do you use?** RIGHT LEFT
Referred by:		**DOB:**	
Referred for:		**Primary Care (if different from referring Dr):**	

Medical/surgical history	Medications/ herbals/ supplements	Allergies
Preferred pharmacy	Preferred mail order pharmacy	Preferred laboratory

	COMMON CONDITIONS: (please mark yes or no)	**Y**	**N**
1.	Diabetes		
2.	High Blood Pressure		
3.	Kidney Disease		
4.	Heart Disease		
5.	Asthma		
6.	Stroke or TIA		
7.	Cancer		
8.	High cholesterol		

Family health history (please list all health conditons for your immediate family)		
	If family member is deceased please list cause and age at death	**Age**
MOTHER		
FATHER		
SIBLINGS		
OTHER		

SOCIAL HISTORY					
Tobacco Use?	☐ **YES** ☐ **NO**	**Packs per day:**	**Quit Date:**		
Alcohol Use?	☐ **YES** ☐ **NO**	**Drinks per week:**		**Caffeine Use?**	☐ **YES** ☐ **NO Type:**
Drug Use? ☐ **YES** ☐ **NO**	☐**CURRENT** ☐**PAST**	**Please list type of drug(s):**			
Disabled: ☐ YES ☐ NO		**Occupation:**		**Last date worked:**	
Birthplace:					

Review of systems [PLEASE CHECK BOX for CURRENT symptoms]		
1. GENERAL	**6. NEUROLOGIC**	**10. GENITAL**
☐ Fever	☐ Dizziness	☐ Breast pain (female)
☐ Chills	☐ Headache	☐ Severe menstrual pain (female)
☐ Recent change in weight	☐ Fainting	☐ Penile pain (male)
☐ Night sweats	☐ Convulsions/seizures	☐ Scrotal pain (male)
☐ Feeling tired or poorly	☐ Paralysis of limbs	☐ Scrotal swelling (male)
☐ Other:	☐ Numbness/tingling of limbs	☐ Sexual dysfunction
	☐ Shaking/tremors	☐ Other:
2. EYES/ VISION	☐ Vertigo (spinning)	
☐ Vision loss/blindness	☐ Poor coordination	**11. MUSCULOSKELETAL**
☐ Eyes watering/ discharge	☐ Other:	☐ Arthritis
☐ Seeing double		☐ Bone infection
☐ Blurry vision	**7. CARDIOVASCULAR**	☐ Neck pain
☐ Drooping eyelid(s)	☐ Chest pain/ discomfort	☐ Sciatica
☐ Other:	☐ Fast heart rate	☐ Back pain
	☐ Low blood pressure	☐ Muscle tissue problem
3. EARS/HEARING	☐ High blood pressure	☐ Other:
☐ Loss of hearing	☐ Leg pain with exercise	
☐ Ringing/buzzing in ears	☐ Cold hands/feet	**12. PSYCHOLOGICAL**
☐ Discharge from the ears	☐ Limb swelling	☐ Emotional problems/concerns
☐ Other:	☐ Other:	☐ Depression
		☐ Feelings of hopelessness
4. NOSE/THROAT	**8. DIGESTIVE SYSTEM**	☐ Anxiety
☐ Hoarseness	☐ Frequent nausea or vomiting	☐ Physical abuse
☐ Sneezing	☐ Vomiting blood	☐ Sexual Abuse
☐ Nasal congestion/blockage	☐ Loss of appetite	☐ Psychological Abuse
☐ Nosebleeds	☐ Abdominal pain	☐ Nightmares
☐ Nasal discharge	☐ Diarrhea	☐ Sudden exhaustion
☐ Difficulty swallowing	☐ Blood in stools	☐ Sleep disturbance
☐ Other:	☐ Constipation	☐ Other:
	☐ Loss of bowel control	
5. RESPIRATORY	☐ Other:	**13. ENDOCRINE**
☐ Wheezing		☐ Excessive thirst
☐ Cough	**9. URINARY**	☐ Intolerant of temperature (hot or cold)
☐ Coughing up sputum	☐ Loss of urinary control	☐ Sudden redness of the skin (flushing)
☐ Shortness of breath	☐ Blood in urine	☐ Nipple discharge
☐ Difficulty breathing	☐ Increased frequency of urine	☐ Other:
☐ Other:	☐ Urinary urgency	
	☐ Delays in starting urine stream	
	☐ Pain during urination	
	☐ Pain in flank	
	☐ Other:	
Revised 4/2016		