

Name: _____	Date: _____	Chart #: _____
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Primary Physician: _____ **Pharmacy Name/Telephone** _____

Your Reason(s) for this visit: _____

List any medication allergies: _____

CURRENT MEDICATIONS: List medications/dosage (If you have a written list, we will make a copy)

1. _____ 2. _____ 3. _____
 4. _____ 5. _____ 6. _____

Do you take blood thinners? NO Yes Aspirin/ Plavix/ Coumadin/ Ginko/ Vit E/ Ginger/ Ginseng extract

MEDICAL HISTORY Circle All That Apply

High Blood Pressure Angina Coronary Artery Disease Irregular Heart Beat Mitral Valve Prolapse OTHER:	Asthma Bronchitis Pneumonia COPD/Emphysema Diabetes	Under/Over Active Thyroid High Cholesterol Kidney-Infection/Stones/Failure Bladder-Infection Failure	Prostate Enlargement Fibroids/Uterine Conditions TIA/ Stroke Seizure	Multiple Sclerosis Bell's Palsy Parkinson's Dementia
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PAST CANCER DIAGNOSIS AND TREATMENT

Breast Lung	Prostate Throat	Brain Bone	Blood Lymph Nodes	Colon Skin	OTHER
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PAST SURGERIES

Hernia Breast Lump Biopsy	Gallbladder Appendix	Open Heart Surgery Carotid Surgery Heart Valve Heart catheterization	Cataract Glaucoma	Tonsils & Adenoids Ear Tubes AAA Repair	Prostate Hysterectomy Artificial Joint
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FAMILY HISTORY: Which Family Member Had/Has the Following Illness? (Mother, Father, Brother, Sister)

Heart Disease	Stroke	Cancer	Anesthesia Problem
Diabetes	Bleeding Disorder	OTHER	

SOCIAL HISTORY: Do you Smoke now? NO Yes: ___Packs/day for ___ years. Stopped smoking ___ years ago.

Alcohol Consumption? No Yes ___drinks per day / Week Pets? No Yes: Dog - Cat - Bird - Hamster

Occupation: Retired Disabled Unemployed Employed as _____ Past Noise Exposure No / Yes

REVIEW OF SYSTEMS: PLEASE CIRCLE IF YOU HAVE ANY OF THE FOLLOWING SYMPTOMS

CONSTITUTIONAL Chills Fever Weight Loss/Gain Tiredness Snoring Daytime Sleepiness	ALLERGY Hives Sneezing Fits Itching Watery/ Itchy Eyes Seasonal Allergies	ENT Hearing Loss Dizziness Ringing Ears Loss of Smell/ Taste Sinus Pain Sore Throat Hoarseness Neck Mass	EYES Partial / Total Blindness Color Blindness Double Vision Blurred Vision Pain Pressure	CARDIOVASCULAR Angina Chest Pain Short of Breath at Rest Swollen feet/ ankles Leg cramps on Walking
RESPIRATORY Shortness of Breath Wheezing Cough Spitting up Blood	ENDOCRINE Excessive Thirst Excessive Hunger Excessive Urination	GASTROINTESTINAL Difficulty Swallowing Heartburn Abdominal Pain Nausea/Vomiting Bowel Irregularity Rectal Bleeding	GENITOURINARY Frequent Urination Painful Urination Blood in Urine Prostate Problems	HEME/LYM Swollen Glands Bleeding Problems Sweating at Night Easy Bruising
DERMATOLOGIC Rash Hives Itching Skin or hair changes	NEURO Headache Passing Out Weakness Numbness, tingling	PSYCH Depression Anxiety or Panic		

