Patient Name: _____ DOB: ____/____/____

Primary Care Doctor: _____ PCP phone #: _____

Medications that you are CURRENTLY taking: _____

_____

_____

Medication Allergies (list all and reactions): _____ ( ) None Known

_____

Patient Height: _____ Weight: _____ Pharmacy name & phone#: _____

Past medical history (check all that apply)

___ Hypertension	___Gastroesophageal reflux disease (GERD)	___Asthma
___Diabetes (type I___ type II___)	___Hepatitis (A or B or C)	___Liver disease
___Coronary artery disease	___Atrial Fibrillation	___Sleep apnea
___Thyroid disease	___Emphysema	___Psychiatric condition
___Seizure	___Migraine headaches	___Stroke
___Kidney disease/failure	___Malignant hyperthermia	___Cancer (site _____)

Please note any other medical conditions: _____

_____

Review of systems (check all that apply)

___fevers	___constipation	___Incoordination	___nipple discharge
___chills	___diarrhea	___lightheadedness	___vaginal discharge
___itchy skin	___nausea or vomiting	___spinning sensation	___runny nose
___frequent colds	___difficulty hearing	___shortness of breath	___nose bleeds
___swollen glands	___light sensitivity	___chronic cough	___nasal obstruction
___headaches	___change in vision	___coughing up blood	___sinus infections
___heartburn	___blood in urine	___easy bleeding/bruising	___neck stiffness
___difficulty swallowing	___blood in stool	___enlarged lymph nodes	___neck pain
___change in voice	___limb weakness	___change in sleep pattern	___CPAP use

Past surgical history and approximate date(s): _____

_____

Are there illnesses that run in your family? (yes / no) What? _____

Are you on a blood thinner? (yes / no) Name: _____

Do you use tobacco products? (yes / no) Have you ever used tobacco products in the past? (yes / no)

What product, how much, low long ago, and (if applicable) how long have your quit? _____

Do you drink alcohol? (yes / no) Do you use recreational drugs? (yes / no) If so, what? _____

Have you had a flu shot this year? (yes / no) If so, approximate date? _____

Have you seen another physician for the condition you're being seen for today? _____

Are there any imaging studies (xr-ays/CT/MRI) performed for this condition? (yes / no) If so, where? _____

_____ _____ Physician Reviewed _____

Signature of patient or legal guardian Date Date_____