

Patient Name _____ Date of Birth _____ Today's Date _____

Referring Physician _____ Primary Care Doctor _____

Reason for today's visit _____

When did this start? _____

MEDICAL HISTORY

Please check if you have ever had any of the following conditions:

- | | | |
|--|--|--|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Cancer, type: _____ |
| <input type="checkbox"/> High Cholesterol | <input type="checkbox"/> Parkinson's Disease | <input type="checkbox"/> Lung problems: _____ |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Gout | <input type="checkbox"/> Eye problems: _____ |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Stroke | <input type="checkbox"/> Heart problems: _____ |
| <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Seizures | <input type="checkbox"/> Other: _____ |

Please list any surgeries you have had and their approximate date/year:

Please list any medication allergies and reactions:

Please list all medications, including vitamins and aspirin, you are currently taking. Please note dosage if possible.

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

Please check if you have any FAMILY HISTORY:

- PROSTATE CANCER KIDNEY STONES OTHER CANCER: _____

PERSONAL HISTORY

Marital Status _____ Do you live with anyone? _____

Occupation _____

Do you currently smoke? _____ Number of cigarettes per day? _____ For how many years? _____

Did you quit smoking? _____ When? _____ How long did you smoke? _____ Amount per day? _____

Do you drink alcohol? _____ Do you use other drugs? _____ If so, what? _____

Current Height: _____ Current Weight: _____

Do you now, or have you had, any recent problems related to the following systems? Please circle YES or NO.

Constitutional Symptoms

Fever Y N
Chills Y N
Unexplained weight change Y N
Other _____

Allergic/Immunologic

Drug allergies Y N
Other _____

Eyes

Acute vision change Y N
Other _____

Ear/Nose/Throat/Mouth

Ear infection Y N
Sore throat Y N
Sinus problems Y N
Other _____

Neurological

Weakness Y N
Dizzy spells Y N
Numbness/tingling Y N
Other _____

Cardiovascular

Chest pain Y N
High blood pressure Y N
Known Heart problems Y N
Other _____

Respiratory

Wheezing Y N
Frequent cough Y N
Shortness of breath Y N
Other _____

Psychiatric

Depression Y N
Other _____

Gastrointestinal

Abdominal pain Y N
Nausea/vomiting Y N
Indigestion/heartburn Y N
Constipation Y N
Fecal incontinence (leakage) Y N
Other _____

Musculoskeletal

Neck pain Y N
Back pain Y N
Other _____

Integumentary

Skin rash Y N
Genital Lesion Y N
Other _____

Endocrine

Excessive thirst Y N
Tired or sluggish Y N
Other _____

Hematologic/Lymphatic

Swollen glands Y N
Blood clotting problem Y N
Other _____

I have read through the full form and answered "YES" to any applicable symptoms. All unmarked symptoms are "NO". Patient signature _____