

Name _____ **Date of Birth** _____ **Age** _____ **Date** _____

Reason for today's visit: _____

Primary Care Physician : _____
Referring Physician : _____

PAST MEDICAL HISTORY : Please circle any following illnesses that you have

Allergy problem	Diabetes	Heart Attack	Lung Disease
Asthma	Reflux	Hepatitis	Seizures
Bleeding Disorders	Glaucoma	Hypertension	Sleep Apnea
Cancer : Type _____	Heart Disease	Kidney Problems	Stroke

Other _____

List any surgeries : _____

List any illnesses for which you were hospitalized: _____

List all current medication: (Amount, Times a day) Include nasal sprays:

List medication allergies _____

SOCIAL HISTORY : Please circle what applies :

Currently Smoke **How many packs daily** _____ **For how many years** _____
Did you previously smoke? **When did you quit?** **Use smokeless tobacco?**
Any smokers in the home _____

Alcohol Use: **None** **Rare** **Minimal** **Moderate** **Heavy**

If in a daycare: **Private or Public** **Grade in School** _____

Occupation _____

FAMILY HISTORY : Please circle whether any relatives have following illnesses :

Allergy	Cancer Type _____
Anesthesia	Hearing Loss
Bleeding Disorder	Heart Problems Diabetes

Please circle symptoms that relate to you :

GENERAL: Chills Fatigue Weight Loss or Gain

SKIN: Dry skin Skin discoloration Rash Hives Skin ulcerations

EYES: Itchy eyes Watery eyes Pain around eyes

RESP: Asthma Cough Coughing blood Shortness of breath Wheezing

CARDIAC: Chest pain Heart murmur Heart trouble
High blood pressure Palpitations Heart attack

GI: Heartburn Reflux Swallowing difficulty

MSK: Arthritis Joint pain Back pain Muscle Weakness

NEURO: Headaches Fainting Seizures

ENDO: Hot flashes Temperature intolerance Thyroid Problems

HEME/LYM : Anemia Bleeding tendency Bruises easily Swollen Nodes/glands

Physician Comments: