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PLEASE ANSWER THE FOLLOWING QUESTIONS TO THE BEST OF YOUR KNOWLEDGE:

PATIENT'S NAME: ______________________________ **AGE:** ____________

FIRST MIDDLE LAST

FAMILY DOCTOR: ______________________________ **DATE:** ____________

PROBLEM: ______________________________

DO YOU HAVE ANY OF THE FOLLOWING ILLNESSES? ***Please check Yes or No***

DIABETES.......................................❍ Yes ❍ No
HEART DISEASE..............................❍ Yes ❍ No
SEIZURES.......................................❍ Yes ❍ No
THYROID DISEASE.........................❍ Yes ❍ No
STROKE...❍ Yes ❍ No
LUNG DISEASE...............................❍ Yes ❍ No

ARTHRITIS.....................................❍ Yes ❍ No
HIGH CHOLESTEROL........................❍ Yes ❍ No
KIDNEY DESEASE.............................❍ Yes ❍ No
HIGH BLOOD PRESSURE..................❍ Yes ❍ No
BLEEDING TENDENCIES...................❍ Yes ❍ No
CANCER...❍ Yes ❍ No
Type ______________________________

PLEASE LIST PREVIOUS SURGERIES — WHEN? ______________________________

____

____

____

CURRENT MEDICATIONS:	DOSAGE (MG):	HOW OFTEN PER DAY?

ARE YOU TAKING ASPRIN OR OTHER BLOOD THINNERS (*Coumadin/Warfarin*)? ❍ Yes ❍ No

ALLERGIES: ______________________________

____

SOCIAL HABITS: **HEIGHT:**____________ **WEIGHT:**____________

USE OF TOBACCO: ❍ **NEVER** ❍ **CURRENT** (*Number of Packs Per Day*) ________ ❍ **QUIT / DATE:**________

USE OF ALCOHOL: ❍ **NEVER** ❍ **OCCASIONALLY** ❍ **DAILY**

FAMILY HISTORY: DOES ANYONE IN YOUR FAMILY HAVE THE FOLLOWING:

❍ **DIABETES** ❍ **STROKE** ❍ **KIDNEY DISEASE** ❍ **HEART DISEASE**

❍ **LUNG DISEASE** ❍ **HIGH BLOOD PRESSURE** ❍ **BLEEDING TENDENCIES** ❍ **SEIZURE DISORDER**

❍ **CANCER** *Type/Who:* ______________________________

(**OVER**)

ARE YOU EXPERIENCING ANY OF THE FOLLOWING?

CONSTITUTIONAL

Fever	❍ Yes	❍ No
Fatigue	❍ Yes	❍ No
Recent Weight Change	❍ Yes	❍ No
Insomnia	❍ Yes	❍ No
Stress	❍ Yes	❍ No

EYES

Wear Glasses / Contacts	❍ Yes	❍ No
Eye / Vision Problems	❍ Yes	❍ No

EARS, NOSE, MOUTH, THROAT

Ear Aches	❍ Yes	❍ No
Hearing Loss / Ringing	❍ Yes	❍ No
Nose Bleeds	❍ Yes	❍ No
Sinus Problems	❍ Yes	❍ No
Frequent Colds	❍ Yes	❍ No
Dental Problems	❍ Yes	❍ No
Sore Throat / Hoarseness	❍ Yes	❍ No

CARDIOVASCULAR

Chest Pain	❍ Yes	❍ No
Irregular / Fast Heartbeat	❍ Yes	❍ No
Cold Extremities	❍ Yes	❍ No
Numbness / Weakness - Arms / Legs	❍ Yes	❍ No
Varicose Veins / Phlebitis	❍ Yes	❍ No
Swelling of Feet / Ankles	❍ Yes	❍ No
Pain When Walking	❍ Yes	❍ No

RESPIRATORY

Coughs	❍ Yes	❍ No
Shortness of Breath	❍ Yes	❍ No
Spitting Up Blood	❍ Yes	❍ No
Asthma / Wheezing	❍ Yes	❍ No

GASTROINTESTINAL

Loss of Appetite	❍ Yes	❍ No
Nausea / Vomiting	❍ Yes	❍ No
Diarrhea	❍ Yes	❍ No
Constipation	❍ Yes	❍ No
Change in Bowels	❍ Yes	❍ No

HEMATOLOGICAL / LYMPHATIC

Slow to Heal After Cuts	❍ Yes	❍ No
Anemia	❍ Yes	❍ No
Blood Transfusions	❍ Yes	❍ No
Bleeding / Bruising	❍ Yes	❍ No
Swollen Glands	❍ Yes	❍ No

ALLERGY / IMMUNOLOGIC

Allergies	❍ Yes	❍ No
Hepatitis	❍ Yes	❍ No
HIV / AIDS	❍ Yes	❍ No

MUSCULOSKELETAL

Joint Pain / Swelling	❍ Yes	❍ No
Muscle Joint Weakness	❍ Yes	❍ No
Back Pain	❍ Yes	❍ No

NEUROLOGICAL

Frequent Headaches	❍ Yes	❍ No
Light Headed / Dizzy	❍ Yes	❍ No
Seizures	❍ Yes	❍ No
Paralysis	❍ Yes	❍ No
Change in Speech	❍ Yes	❍ No

PSYCHIATRIC

Memory Loss / Confusion	❍ Yes	❍ No
Nervousness / Depression	❍ Yes	❍ No

ENDOCRINE

Hormone Problem	❍ Yes	❍ No
Excessive Thirst or Urination	❍ Yes	❍ No
Heat / Cold Intolerance	❍ Yes	❍ No

INTEGUMENTARY / BREAST

Rash / Itching	❍ Yes	❍ No
Change in Skin / Hair / Nails	❍ Yes	❍ No
Yellow Jaundice	❍ Yes	❍ No
Breast Pain	❍ Yes	❍ No
Breast Lump	❍ Yes	❍ No
Nipple Discharge / Bleeding	❍ Yes	❍ No

GENITOURINARY

Frequent Urination	❍ Yes	❍ No
Painful / Burning Urination	❍ Yes	❍ No
Bladder Control Problem	❍ Yes	❍ No
Kidney Stones	❍ Yes	❍ No
Change in Force or Stream	❍ Yes	❍ No
Venereal Disease	❍ Yes	❍ No

WOMEN (ONLY)

Last Menstrual Period:	___________	
How Many Pregnancies?	___________	
How Many Full Term?	___________	
How Many Miscarriages?	___________	
Age at First Menstrual Period:	___________	
Age at First Pregnancy:	___________	
Did You Breast Feed?	❍ Yes	❍ No

MALES (ONLY)

Testicle Pain	❍ Yes	❍ No
Prostate Problems	❍ Yes	❍ No

Signature ______________________________