PLEASE CHECK ANY ILLNESSES YOU HAVE/HAD, AND IF POSSIBLE PLEASE ENTER YEAR OF DIAGNOSIS.

NAME: ____DATE OF BIRTH: _____/_____/_____

PAST MEDICAL HISTORY:

Yes	APPROXIMATE YEAR OF DIAGNOSIS
☐ ALLERGIES (Seasonal)____________________	____________________
☐ ANEMIA ____________________	____________________
☐ ARTHRITIS ____________________	____________________
☐ ASTHMA____________________	____________________
☐ ATRIAL FIBRILLATION____________________	____________________
☐ BLOOD CLOTS____________________	____________________
☐ BROKEN BONES AFTER THE AGE OF 50_______	____________________
☐ CANCER (specify type of cancer) ____________	____________________
☐ CONGESTIVE HEART FAILURE______________	____________________
☐ CORONARY ARTERY DISEASE_______________	____________________
☐ DEPRESSION/ANXIETY____________________	____________________
☐ DIABETES____________________	____________________
☐ ELEVATED LIPIDS/CHOLESTEROL____________	____________________
☐ FIBROMYALGIA____________________	____________________
☐ GASTROINTESTINAL (GI) BLEED_____________	____________________
☐ GERD/REFLUX____________________	____________________
☐ GOUT____________________	____________________
☐ HEADACHE/MIGRAINE____________________	____________________
☐ HEPATITIS/LIVER DISEASE________________	____________________
☐ HYPERTENSION/ HIGH BLOOD PRESSURE______	____________________
☐ IRRITABLE BOWEL SYNDROME______________	____________________
☐ INFLAMMATORY BOWEL DISEASE (CROHN'S OR ULCERATIVE COLITIS)____________________	
☐ LUPUS ____________________	____________________
☐ MYOCARDIAL INFARCTION/HEART ATTACK_____	____________________
☐ OSTEOPOROSIS (THIN OR BRITTLE BONES)______	____________________
☐ PERIPHERAL NEUROPATHY________________	____________________
☐ PERIPHERAL VASCULAR DISEASE____________	____________________
☐ PSORIASIS____________________	____________________
☐ RENAL/KIDNEY DISEASE ________________	____________________
☐ SEIZURES____________________	____________________
☐ STOMACH OR DUODENAL ULCERS____________	____________________
☐ STROKE____________________	____________________
☐ TIA (MINI-STROKE) ____________________	____________________
☐ THYROID DISEASE____________________	____________________
☐ TUBERCULOSIS____________________	____________________
☐ OTHER ILLNESSES (PLEASE LIST)____________	____________________
____________________	____________________
____________________	____________________
____________________	____________________
____________________	____________________

TURN OVER

PAST SURGICAL HISTORY: PLEASE LIST ALL SURGERIES/OPERATIONS YOU HAVE HAD, AND IF YOU REMEMBER, PLEASE ENTER THE YEAR WHEN THEY WERE DONE.

____
____
____
____
____

FAMILY HISTORY:

DO YOU KNOW OF ANY RELATIVE WHO HAS, OR HAS HAD THE FOLLOWING:
(Please enter **F** for Father, **M** for Mother, **S** for Sister, **B** for Brother, **GM** for Grandmother and **GF** for Grandfather, **C** for Cousin, **A** for Aunt and **U** for Uncle)

FATHER ALIVE ☐ DECEASED ☐ IF DECEASED, CAUSE OF DEATH ____________________
MOTHER ALIVE ☐ DECEASED ☐ IF DECEASED, CAUSE OF DEATH ____________________
NUMBER OF SIBLINGS (SISTERS/BROTHERS) ____________ LIVING________ DECEASED________
NUMBER OF CHILDREN YOU HAVE______________ LIST AGES ________________________

ARTHRITIS______________ BLOOD CLOTS______________ CANCER______________
CARDIOVASCULAR DISEASE __________ ELEVATED LIPIDS/CHOLESTEROL ______________
HYPERTENSION (HIGH BLOOD PRESSURE) ____
INFLAMMATORY BOWEL DISEASE (CROHN'S OR ULCERATIVE COLITIS) __________________
LUPUS ________________ PERIPHERAL VASCULAR DISEASE ________________________
PSORIASIS ______________ STROKE ________________ TUBERCULOSIS ______________
DIABETES______________ FIBROMYALGIA__________ GOUT____________

DID EITHER PARENT EVER BREAK A HIP? YES ☐ NO ☐

DO YOU CURRENTLY SMOKE? YES ☐ NO ☐
IF SO, HOW MANY CIGARETTES PER DAY? __________________________
HOW LONG HAVE YOU BEEN A SMOKER? __________YEARS

HAVE YOU EVER SMOKED IN THE PAST? YES ☐ NO, NEVER ☐
IF SO, WHEN DID YOU QUIT? ________________________________
HOW LONG DID YOU SMOKE? _____ YEARS______________________________
HOW MANY CIGARETTES PER DAY? ______________________________

DO YOU DRINK ANY ALCOHOL? YES ☐ NO ☐
IF SO, HOW MANY DRINKS PER WEEK? ______________________________________
IF NOT, DID YOU DRINK ALCOHOL IN THE PAST? YES ☐ NO ☐
IF YES, HOW MUCH? ____

DO YOU EXERCISE? YES ☐ NO ☐
HOW MUCH AND HOW OFTEN? ____

SINGLE ☐ MARRIED ☐ WIDOWED ☐ DIVORCED ☐ SEPARATED ☐ PARTNER ☐

HIGHEST LEVEL OF EDUCATION: ELEMENTARY SCHOOL MIDDLE SCHOOL HIGH SCHOOL COLLEGE GRADUATE SCHOOL
OCCUPATION:
____

TODAY'S DATE: _____/_____/_____

NAME: ________________________________ DATE OF BIRTH: _____/_____/_____
TODAY'S DATE:________________________
REVIEW OF SYSTEMS:

PLEASE CHECK SYMPTOMS YOU CURRENTLY HAVE (MARK WITH A **C**) OR HAVE HAD IN THE LAST 2 MONTHS (MARK WITH A **P** IF NO LONGER PRESENT)

- ☐ FEVER
- ☐ CHILLS
- ☐ FATIGUE
- ☐ WEIGHT GAIN
- ☐ WEIGHT LOSS

- ☐ SKIN RASHES
- ☐ FINGERS TURNING BLUE OR WHITE WITH COLD EXPOSURE
- ☐ SUN SENSITIVITY/RASH
- ☐ PSORIASIS
- ☐ HIVES
- ☐ SIGNIFICANT HAIR LOSS

- ☐ SWOLLEN GLANDS/LYMPHNODES

- ☐ DRY EYES
- ☐ DRY MOUTH
- ☐ EYE INFLAMMATION
- ☐ MOUTH SORES
- ☐ RECURRENT SINUS INFECTIONS
- ☐ VISION CHANGES

- ☐ SHORTNESS OF BREATH
- ☐ COUGH
- ☐ WHEEZING
- ☐ PAINFUL BREATHING
- ☐ EXCESSIVE SNORING

- ☐ CHEST PAIN
- ☐ PALPITATIONS
- ☐ SWELLING OF LEGS

- ☐ ABDOMINAL PAIN
- ☐ HEARTBURN

- ☐ NAUSEA
- ☐ VOMITING
- ☐ DIARRHEA
- ☐ CONSTIPATION
- ☐ EXCESSIVE GAS
- ☐ BLOOD IN STOOLS

- ☐ PAIN OR BURNING ON URINATION
- ☐ BLOOD IN URINE
- ☐ GETTING UP TOO OFTEN AT NIGHT TO URINATE
- ☐ RECURRENT URINARY TRACT INFECTIONS
- ☐ URINARY FREQUENCY
- ☐ URINARY INCONTINENCE
- ☐ GENITAL ULCERS

- ☐ COLD INTOLERANCE
- ☐ HEAT INTOLERANCE
- ☐ HOT FLASHES
- ☐ EXCESSIVE THIRST

- ☐ HEADACHES
- ☐ NUMBNESS/TINGLING
- ☐ MEMORY PROBLEMS
- ☐ DEPRESSION/ANXIETY
- ☐ SEIZURES

- ☐ EXCESSIVE BRUISING
- ☐ EASY BLEEDING

- ☐ MUSCLE CRAMPING
- ☐ JOINT PAIN
- ☐ MUSCLE PAIN
- ☐ WIDESPREAD PAIN

ARE YOU ALLERGIC TO ANY MEDICATIONS? LIST MEDICATIONS AND REACTIONS:
____
____
____
____
____
____

TURN OVER

MEDICATION LIST:

PLEASE LIST ALL CURRENT MEDICATIONS, INCLUDING VITAMINS, SUPPLEMENTS and OVER THE COUNTER MEDICATIONS:

MEDICATION NAME: DOSE: HOW OFTEN: