

Name: _____ Date: _____

Allergies:

Please list any allergies that you have: _____

Medications:

Please list any medications that you are taking: _____

Past Medical History: Do you have or have you had any of the following medical conditions:

Alzheimer's disease	yes	no	Kidney Disease	yes	no
Anemia	yes	no	Liver condition	yes	no
Arthritis conditions	yes	no	Lung disease	yes	no
Asthma	yes	no	Lymes Disease	yes	no
Cancer	yes	no	Neurological Disease	yes	no
Diabetes	yes	no	Osteoporosis	yes	no
Ear conditions	yes	no	Phlebitis	yes	no
Epileps	yes	no	Poor circulation	yes	no
Eye conditions	yes	no	Rheumatic Fever	yes	no
Gout	yes	no	Sciatica	yes	no
Headaches	yes	no	Stroke	yes	no
Heart attacks	yes	no	Thyroid Disorder	yes	no
Hepatitis	yes	no	Tuberculosis	yes	no
High cholesterol	yes	no	Ulcers	yes	no
Hypertension	yes	no	Psychiatric Disorder	yes	no
Keloids	yes	no	Respiratory Disease	yes	no

Please list any other medical conditions that you have or had: _____

Please list any surgeries you may have had: _____

Systems Review: Please circle yes or no

Allergic reactions	yes	no	Eye or vision problems	yes	no
Bleeding problems	yes	no	GI symptoms	yes	no
Breathing difficulties	yes	no	Genitourinary problems	yes	no
Cardiovascular problems	yes	no	Joint or muscle pain	yes	no
Fever, headache, nausea or dizziness	yes	no	Neurological symptoms	yes	no
Ears, nose, mouth, throat symptoms	yes	no	Psychiatric difficulties	yes	no
Endocrine related problems	yes	no	Skin related problems	yes	no

Family History:

Please list immediate family members who have/had the following:

Arthritis _____	Diabetes _____
Birth Defects _____	Foot Problems _____
Bleeding disorders _____	Heart Conditions _____
Cancer _____	Hypertension _____
Stroke _____	

Social History: *Please circle yes or no*

Tobacco	yes	no	How many packs per day _____	Years _____		
Alcohol	yes	no	Rarely	Moderately	Daily	Quit
Illegal Drugs	yes	no	Rarely	Moderately	Daily	Quit

Are you currently pregnant? yes no

Please circle your marital status

single married separated divorced widowed

What is your chief complaint: _____

How long has this been a problem for you? _____ days weeks months years

Previous treatment: _____

Is there anything else you would like the doctor to know: _____

DOCTOR'S NOTES: _____

