Name:____ **Date**:_____________________

What is your chief complaint: ____

____

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

Tobacco Use yes no quit How many packs per day________ Years_______

Mothers Name:________________________________ Alive Deceased Unknown Age: __________

Fathers Name:________________________________ Alive Deceased Unknown Age: __________

Previous Surgeries:____

____

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

Cardiovascular

Heart attacks	yes	no
Hypertension	yes	no
High cholesterol	yes	no
Lyphedema	yes	no
Phlebitis	yes	no
Poor circulation	yes	no
Stroke	yes	no

Dermatologic

Keloids	yes	no
Eczema	yes	no
Melanoma	yes	no
Skin Problems	yes	no
Ulcers	yes	no

Endocrine

Diabetes	yes	no
Thyroid disorder	yes	no
Weight Change	yes	no

Gastrointestinal

Liver condition	yes	no
Stomach/Bowel Problems	yes	no

Cancer Yes no Explain:

Genitourinary

Kidney disease	yes	no
Pregnant	yes	no

Head, Eyes, Ear, Nose, Throat

Ear Conditions	yes	no
Eye Conditions	yes	no
Headaches	yes	no
Migraines	yes	no
Nose Conditions	yes	no
Throat Conditions	yes	no

Hematologic/Lymphatic

Anemia	yes	no
Bleeding Tendencies	yes	no
Blood /Lymphatic Problems	yes	no

Immunologic

AIDS/HIV	yes	no
Hepatitis A B C	yes	no
Lymes disease	yes	no
Lupus	yes	no

Musculoskeletal

Ankle Injury	yes	no
Arthritis Conditions	yes	no
Back Problems	yes	no
Fibromyalgia	yes	no
Fracture History	yes	no
Gout	yes	no
Osteoporosis	yes	no

Neurological

Epilepsy	yes	no
Neurological Symptoms	yes	no
Neuropathy	yes	no
Sciatica	yes	no

Psychiatric

Alzheimer’s disease	yes	no
Dementia	yes	no
Psychiatric disorder	yes	no

Respiratory

Asthma	yes	no
Respiratory Condition	yes	no
Tuberculosis	yes	no

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

____

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

Arthritis___________________________________ Foot problems______________________________

Birth defects_______________________________ Heart conditions____________________________

Bleeding disorders___________________________ Hypertension______________________________

Cancer____________________________________ Respiratory disorders________________________

Diabetes___________________________________ Stroke___________________________________

Have you had a flu shot? Yes No Date: ______________

Have you had a Pneumonia Vaccination? Yes No Date: ______________

Social History: Please circle yes or no

Alcohol yes no quit Rarely Social Daily

Illegal Drugs yes no quit Rarely Moderate Daily

Occupation: ____

Marital Status: Divorced Married Remarried Separated Single Widow Domestic Partnership

Allergies and reaction:____

____

Current Medications: ____

____

____

____

____

Below for office use only

Height: ______________________ Weight: ______________________

Blood Pressure: __________________ Pulse: _________________ BMI:_______________

Pulses: Right - DP - 0 1 2 3 4/4 PT- 0 1 2 3 4/4 Left- DP - 0 1 2 3 4/4 PT- 0 1 2 3 4/4

DOCTOR'S NOTES: ____

____

____

____

____

____

Review of systems
(Current symptoms)

NAME:____ Date:__________________

General-
☐ Weight loss or gain
☐ Fatigue
☐ Fever or chills
☐ Weakness
☐ Trouble sleeping

Skin-
☐ Rashes
☐ Lumps
☐ Itching
☐ Dryness
☐ Color changes
☐ Hair and nail changes

Head-
☐ Headache
☐ Head injury
☐ Neck Pain

Ears-
☐ Decreased hearing
☐ Ringing in ears
☐ Earache
☐ Drainage

Eyes-
☐ Vision Loss/Changes
☐ Glasses or contacts
☐ Pain
☐ Redness
☐ Blurry or double vision
☐ Flashing lights
☐ Specks
☐ Glaucoma
☐ Cataracts
☐ Last eye exam

Nose-
☐ Stuffiness
☐ Discharge
☐ Itching
☐ Hay fever
☐ Nosebleeds
☐ Sinus pain

Throat-
☐ Bleeding
☐ Dentures
☐ Sore tongue
☐ Dry mouth
☐ Sore throat
☐ Hoarseness
☐ Thrush
☐ Non-healing sores

Neck-
☐ Lumps
☐ Swollen glands
☐ Pain
☐ Stiffness

Breasts-
☐ Lumps
☐ Pain
☐ Discharge
☐ Self-exams
☐ Breast-feeding

Respiratory-
☐ Cough
☐ Sputum
☐ Coughing up blood
☐ Shortness of breath
☐ Wheezing
☐ Painful breathing

Cardiovascular-
☐ Chest pain or discomfort
☐ Tightness
☐ Palpitations
☐ Shortness of breath with activity
☐ Difficulty breathing lying down
☐ Swelling
☐ Sudden awakening from sleep with shortness of breath

Gastrointestinal-
☐ Swallowing difficulties
☐ Heartburn
☐ Change in appetite
☐ Nausea
☐ Change in bowel habits
☐ Rectal bleeding
☐ Constipation
☐ Diarrhea
☐ Yellow eyes or skin

Urinary-
☐ Frequency
☐ Urgency
☐ Burning or pain
☐ Blood in urine
☐ Incontinence
☐ Change in urinary strength

Vascular-
☐ Calf pain with walking
☐ Leg cramping

Musculoskeletal-
☐ Muscle or joint pain
☐ Stiffness
☐ Back pain
☐ Redness of joints
☐ Swelling of joints
☐ Trauma

Neurologic-
☐ Dizziness
☐ Fainting
☐ Seizures
☐ Weakness
☐ Numbness
☐ Tingling
☐ Tremor

Hematologic-
☐ Ease of bruising
☐ Ease of bleeding

Endocrine-
☐ Head or cold intolerance
☐ Sweating
☐ Frequent urination
☐ Thirst
☐ Change in appetite

Psychiatric-
☐ Nervousness
☐ Stress
☐ Depression
☐ Memory loss