Patient Name: _____ **DOB:** _____ **Acct #** _____

For what reason are you here today? _____
_____

Please check conditions which you have had?

GENERAL
□ Serious Infections (e.g. pneumonia)
□ Diabetes Mellitus
□ Rheumatic Fever
□ HIV Infection
□ Cancer (where)_____

CVS
□ High Blood Pressure
□ Congestive Heart Failure
□ Heart Murmur
□ Abnormal Heart Rhythm
□ High cholesterol
□ Heart Valve Disease
□ Angina
□ Heart Attack
□ Blood Clots in Veins
□ Blocked Arteries in Legs
□ Blocked Arteries in Neck

HEENT
□ Glaucoma
□ Allergies "hay fever"
□ Frequent Ear Infections
□ Frequent Sinus Infections

RESPIRATORY
□ Sleep Apnea
□ Asthma
□ Emphysema
□ Blood Clots in Lungs

MUSCULOSKELETAL / EXTREMITIES
□ Rheumatoid Arthritis
□ Osteoporosis
□ Fibromyalgia
□ Degenerative Joint Disease
□ Neck Pain (herniated disc)
□ Back Pain (herniated disc)

LYMPHATIC / HEMATOLOGIC
□ Thyroid Goiter
□ Over Active Thyroid
□ Under Active Thyroid
□ Transfusions
□ Anemia

GI / GU
□ Stomach Ulcers
□ Ulcerative Colitis
□ Crohns Disease
□ Intestinal Bleeding
□ Diverticulitis
□ Gallstones
□ Colon Polyps
□ Irritable Bowel Disease
□ Hepatitis
□ Cirrhosis of the Liver
□ Liver Failure
□ Pancreatitis

□ Kidney Stones
□ Kidney Failure
□ Endometriosis
□ Sex Transmitted Infection
□ Prostate Disease

SKIN / BREAST
□ Eczema
□ Psoriasis
□ Fibrocystic Breast Disease
□ Acne

NEUROLOGIC / PSYCHIATRIC
□ Chronic Vertigo (Meniere's)
□ Migraine Headaches
□ Peripheral Nerve Disease
□ Stroke
□ Multiple Sclerosis
□ Depression
□ Anxiety

Doctor's Notes:_____
_____
_____

Please indicate any surgeries you have had and the year you had them.

Year	Year	Year	Year
____Angioplasty	____Trauma Related Surgery	____Stomach Surgery	____Tubal Ligation
____Carotid Artery Surgery	____Back or Neck Surgery	____Inguinal Hernia	____C-Section
____Other Vascular Surgery	____Hip Surgery	____Gallbladder	____Hysterectomy
____Coronary Bypass Surgery	____Knee Surgery	____Appendectomy	____Ovary Removed
____Chest / Lung Surgery	____Carpal Tunnel Surgery	____Prostate Surgery	____Breast Surgery
____Tonsillectomy	____Sinus Surgery	____Bladder Surgery	____Thyroid Surgery
____Neurosurgery	____Ear Surgery	____Other _____	

Doctor's Notes:_____
_____
_____

Please indicate when you last had any of the following preventative tests or services.

Year	Year	Year	Year
____Cardiac Angiogram	____Flu Vaccine	____Prostate Cancer Blood Test	____Colonoscopy
____Stress Test	____Pneumonia Vaccine	____Rectal Exam	____Mammogram
____Echocardiogram	____Tetanus Vaccine	____Colon Cancer Stool Test	____Pap Smear
____Chest X-Ray	____Hepatitis Vaccine	____Flexible Sigmoidoscopy	____Date of last Physical
____EKG	____Bone Density Test	____Barium Enema	____Other _____

Doctor's Notes: _____
_____
_____

Please list any allergies or intolerance to drugs or other substances. _____

_____
_____
_____
_____

Please list the medications currently taken, their dosages and how many times per day you take them.

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

FAMILY MEDICAL HISTORY

Please check or list any major illness in your family members. (Mother, Father, Grandparent, Brothers, Sisters or Children)

	Family Relation		Family Relation
□ Tuberculosis	_____	□ Kidney Disease	_____
□ Emphysema	_____	□ Epilepsy	_____
□ Heart Disease	_____	□ Neurological Disorder	_____
□ High Blood Pressure	_____	□ Liver Disease	_____
□ Osteoporosis	_____	□ Breast Cancer	_____
□ Diabetes Mellitus	_____	□ Ovarian Cancer	_____
□ Thyroid Disease	_____	□ Colon Cancer	_____
□ Anemia	_____	□ Prostate Cancer	_____
□ Hemophilia	_____	□ Other	_____

Notes:
_____
_____

PERSONAL INFORMATION

Please write in or circle the information that applies to you:

Occupation:

Education	**Marital Status**	**Living Status**	**Diet**	**Exercise**	**Alternative Medicine**
Primary	Single	Alone	None	None	Holistic
Secondary	Married	With Spouse	Low Fat	Walking	Chiropractic
College	Divorced	With Parents	Low Cholesterol	Aerobics	Homeopathy
Post grad	Widowed	Assisted Living	Low Carb	Weightlifting	Acupuncture
Doctorate	Separated	Nursing Home	Vegetarian	____ Days/Wk	Herbal

Tobacco	**Alcohol**	**Illicit Drugs**	**Caffeine**
never / past / active	never / past / active	never / past / active	never / past / active
cigarette / cigar / pipe	liquor / wine / beer	Cocaine / Marijuana	Coffee / Tea / Soda
snuff / dip / chewing	_____drinks per	Heroin / Amphetamine	_____Cans / Cups per day
Start _____ Stop _____	day / week / month	Barbiturate / LSD / PCP	
packs per day _____	AA / Alcohol Rehab	IV Drug Abuse / Drug Rehab	

Doctor's Notes:

_____
_____
_____