Please fill in circles below

Patient Name _____ Date of Birth_____

Do you use any Tobacco? O current smoker O nonsmoker

Do you use alcohol? O Yes O No O Socially O Recovering

Have you used recreational drugs? O Yes O No

Caffeine intake? O Yes O No

Do you exercise regularly? O Yes O No

Marital Status:

Are you currently O Single O Married O Divorced O Widowed

Family History:

Status A=Alive D=Deceased

Father: O A O D O Cancer O Diabetes O Mental Illness O Hypertension
O Heart Disease O Stroke O Unknown

Mother: O A O D O Cancer O Diabetes O Mental Illness O Hypertension
O Heart Disease O Stroke O Unknown

Children: O A O D O Cancer O Diabetes O Mental Illness O Hypertension
O Heart Disease O Stroke O Unknown

Siblings: O A O D O Cancer O Diabetes O Mental Illness O Hypertension
O Heart Disease O Stroke O Unknown

Past Medical History

O High Blood Pressure O Heart Attack O Diabetes O Asthma O Thyroid Disorder
O Stroke O Cancer

Current Medical Problem

O High Blood Pressure O Coronary Artery Disease O Diabetes O Asthma
O Thyroid Disorder O Congestive Heart Failure O COPD O GERD

Patient Name: _____ **Date of Birth:** _____

General

Fever	O Yes	O No
Chills	O Yes	O No
Night sweats	O Yes	O No
Fatigue	O Yes	O No
Weakness	O Yes	O No
Change in Weight	O Yes	O No

Eyes

Eye irritation	O Yes	O No
Seasonal eye symptoms	O Yes	O No
Change in vision	O Yes	O No
Cataracts	O Yes	O No
Glaucoma	O Yes	O No

Ear, Nose, Throat

Ear Symptoms	O Yes	O No
Sinus Problems	O Yes	O No
Frequent nosebleed	O Yes	O No
Change in Hearing	O Yes	O No
Sore throat / Difficulty Swallowing	O Yes	O No
Change in Voice	O Yes	O No

Cardiovascular

Chest pain	O Yes	O No
Palpitations	O Yes	O No
High blood pressure	O Yes	O No
Swelling of hands/feet	O Yes	O No

Respiratory

Shortness of breath	O Yes	O No
Cough	O Yes	O No
Blood-tinged sputum	O Yes	O No

Gastrointestinal

Nausea / Vomiting	O Yes	O No
Abdominal pain	O Yes	O No
Heartburn / Indigestion	O Yes	O No
Change in Appetite	O Yes	O No
Change in bowels	O Yes	O No

Musculoskeletal

Muscle Pain / Cramping	O Yes	O No
Joint stiffness	O Yes	O No
Joint swelling	O Yes	O No
Joint pain	O Yes	O No

Neurological

Tremors / Paralysis	O Yes	O No
Seizures / Strokes	O Yes	O No
Tingling / Numbness	O Yes	O No
Trouble with balance	O Yes	O No

Skin

Change in hair/nails	O Yes	O No
Suspicious lesions/moles	O Yes	O No
Rash/Itching	O Yes	O No
Healing problems	O Yes	O No

Endocrine

Excessive thirst	O Yes	O No
Thyroid disorder	O Yes	O No
Abnormal Breast Problems	O Yes	O No

Hematologic / Lymphatic

Easy bruising	O Yes	O No
Easy bleeding	O Yes	O No
Swollen glands	O Yes	O No
Slow healing	O Yes	O No

Urology

Urinary incontinence	O Yes	O No
Urinary frequency	O Yes	O No
Pain with urination	O Yes	O No
Blood in urine	O Yes	O No
Kidney disease	O Yes	O No

Psychiatric

Anxiety	O Yes	O No
Depression	O Yes	O No
Memory loss	O Yes	O No
Mental Illness	O Yes	O No

Male - Only

Hernia	O Yes	O No
Testicular pain or swelling	O Yes	O No
Sexual Problems	O Yes	O No

Female - Only

Pelvic pain	O Yes	O No
Menstrual Problems	O Yes	O No
Sexual Problems	O Yes	O No