

PATIENT HISTORY (Please Print)

Patient Name:	First _____	Middle _____	Last _____	Age _____	Sex M <input type="checkbox"/> F <input type="checkbox"/>
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Medical Allergies None **If you have allergies, please list the type of reaction you have when taking the medication**

Name of Medication	Type of Reaction	Name of Medication	Type of Reaction

Past Medical History: Please below under the "yes" column or "no" column to indicate any problems you have had in the past.

G E N E R A L	YES	NO		G I	YES	NO		OB History	Life Style																																	
G E N E R A L	<input type="checkbox"/>	<input type="checkbox"/>	Skin Rash	G I	<input type="checkbox"/>	<input type="checkbox"/>	Stomach Pain	# of Pregnancies _____ # Live Births _____ # Abortions _____	Height _____ Usual Weight _____ lb Weight Change in past Year: Gained _____ lb Lost _____ lb																																	
	<input type="checkbox"/>	<input type="checkbox"/>	Weakness		<input type="checkbox"/>	<input type="checkbox"/>	Constipation																																			
	<input type="checkbox"/>	<input type="checkbox"/>	No Appetite		<input type="checkbox"/>	<input type="checkbox"/>	Loose Stools																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Chills/Sweats		<input type="checkbox"/>	<input type="checkbox"/>	Change in Bowels																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Sleeping Difficulty		<input type="checkbox"/>	<input type="checkbox"/>	Black Stools																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Prolonged Fever		<input type="checkbox"/>	<input type="checkbox"/>	Bloody Stools																																			
H E A D	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Headache	G U	<input type="checkbox"/>	<input type="checkbox"/>	Frequent Urination	Operations (show year) <input type="checkbox"/> None <input type="checkbox"/> Tonsils <input type="checkbox"/> Appendix <input type="checkbox"/> Gallbladder <input type="checkbox"/> Hernia <input type="checkbox"/> Abdomen <input type="checkbox"/> Heart <input type="checkbox"/> Lungs <input type="checkbox"/> Breast or female organs <input type="checkbox"/> Eyes	How many meals do you Eat daily? _____ Do you exercise? <input type="checkbox"/> No <input type="checkbox"/> Yes (list type)																																	
	<input type="checkbox"/>	<input type="checkbox"/>	Migraines		<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Holding Urine																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Dizzy Spells		<input type="checkbox"/>	<input type="checkbox"/>	Difficulty Starting Urine																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Fainting		<input type="checkbox"/>	<input type="checkbox"/>	Painful Urination																																			
E Y E S	<input type="checkbox"/>	<input type="checkbox"/>	Wears Glasses	N E R V O U S	<input type="checkbox"/>	<input type="checkbox"/>	Discharge	Medication & Supplements (List all you take including herbs) <input type="checkbox"/> None <input type="checkbox"/> See Attached List Aspirin? <input type="checkbox"/> Yes <input type="checkbox"/> No Ibuprofen? <input type="checkbox"/> Yes <input type="checkbox"/> No Calcium? <input type="checkbox"/> Yes <input type="checkbox"/> No Vitamins? <input type="checkbox"/> Yes <input type="checkbox"/> No	Tobacco: <input type="checkbox"/> Dip / Chew <input type="checkbox"/> Cigars <input type="checkbox"/> Cigarettes Packs per day _____ # of Years _____ Years Stopped _____																																	
	<input type="checkbox"/>	<input type="checkbox"/>	Major Vision Change		<input type="checkbox"/>	<input type="checkbox"/>	Kidney Stones																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Blurred vision		<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy																																			
	<input type="checkbox"/>	<input type="checkbox"/>	See Double		<input type="checkbox"/>	<input type="checkbox"/>	Dizziness																																			
E A R S	<input type="checkbox"/>	<input type="checkbox"/>	Eye Pain/Itching	B O N E S	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	Medication Dose	Caffeine: Cups per day _____ Alcohol: <input type="checkbox"/> Never <input type="checkbox"/> Occasional <input type="checkbox"/> Moderate <input type="checkbox"/> Heavy																																	
	<input type="checkbox"/>	<input type="checkbox"/>	Earache		<input type="checkbox"/>	<input type="checkbox"/>	Can't Make Decisions																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Drainage		<input type="checkbox"/>	<input type="checkbox"/>	Memory Problems																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Noise in Ears		<input type="checkbox"/>	<input type="checkbox"/>	Depressed/Feel Sad																																			
N O S E	<input type="checkbox"/>	<input type="checkbox"/>	Trouble Hearing	O T H E R	<input type="checkbox"/>	<input type="checkbox"/>	Considered Suicide	Has anyone in your immediate Family had any of the following? <table style="width:100%; border:none;"> <tr> <td style="width:5%;">YES</td> <td style="width:5%;">NO</td> <td> </td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Diabetes</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>High Blood Pressure</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Heart Attack</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Stroke</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Cancer</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Site _____</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Mental Illness</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Suicide</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Neurologic Diseases such as</td> </tr> <tr> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td>Migraine, Alzheimer's</td> </tr> </table>	YES	NO		<input type="checkbox"/>	<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Site _____	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	Suicide	<input type="checkbox"/>	<input type="checkbox"/>	Neurologic Diseases such as	<input type="checkbox"/>	<input type="checkbox"/>	Migraine, Alzheimer's	Have you ever used illegal or street drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes (list type)
	YES	NO																																								
	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes																																							
	<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure																																							
	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack																																							
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<input type="checkbox"/>	<input type="checkbox"/>	Migraine, Alzheimer's																																								
<input type="checkbox"/>	<input type="checkbox"/>	Earache	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Fear																																					
<input type="checkbox"/>	<input type="checkbox"/>	Drainage	<input type="checkbox"/>	<input type="checkbox"/>	Aching Joints																																					
<input type="checkbox"/>	<input type="checkbox"/>	Noise in Ears	<input type="checkbox"/>	<input type="checkbox"/>	Aching Muscles																																					
<input type="checkbox"/>	<input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>	Leg Cramps																																					
T H R O A T	<input type="checkbox"/>	<input type="checkbox"/>	Congestion	F A M I L Y	<input type="checkbox"/>	<input type="checkbox"/>	Leg Pain	Education Completed <input type="checkbox"/> Grade <input type="checkbox"/> High <input type="checkbox"/> Business/Vocational <input type="checkbox"/> College	Occupation(s): <input type="checkbox"/> Retired																																	
	<input type="checkbox"/>	<input type="checkbox"/>	Sneezing		<input type="checkbox"/>	<input type="checkbox"/>	Painful Feet																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Sinus Trouble		<input type="checkbox"/>	<input type="checkbox"/>	Polio																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Hay Fever		<input type="checkbox"/>	<input type="checkbox"/>	Pain in Arms																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Nose Bleeds		<input type="checkbox"/>	<input type="checkbox"/>	Numbness Arms/Legs																																			
H E A R T	<input type="checkbox"/>	<input type="checkbox"/>	Sore Throat/Tongue	H I S T O R Y	<input type="checkbox"/>	<input type="checkbox"/>	Highs Cholesterol	Fall & Assist Devices Do you use or have installed any of these devices or equipment? Quad Cane <input type="checkbox"/> Yes <input type="checkbox"/> No Walker <input type="checkbox"/> Yes <input type="checkbox"/> No Wheelchair <input type="checkbox"/> Yes <input type="checkbox"/> No Shower Bars <input type="checkbox"/> Yes <input type="checkbox"/> No Raised Toilets <input type="checkbox"/> Yes <input type="checkbox"/> No	Have you ever used illegal or street drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes (list type)																																	
	<input type="checkbox"/>	<input type="checkbox"/>	Hoarse		<input type="checkbox"/>	<input type="checkbox"/>	Diabetes																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Dental Problems		<input type="checkbox"/>	<input type="checkbox"/>	Excessive Thirst																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Goiter		<input type="checkbox"/>	<input type="checkbox"/>	Cancer																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Trouble		<input type="checkbox"/>	<input type="checkbox"/>	Site _____																																			
L U N G S & H E A R T	<input type="checkbox"/>	<input type="checkbox"/>	Neck Pain/Lumps	H I S T O R Y	<input type="checkbox"/>	<input type="checkbox"/>	Mental Illness	Occupation(s): <input type="checkbox"/> Retired	Have you ever used illegal or street drugs? <input type="checkbox"/> No <input type="checkbox"/> Yes (list type)																																	
	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing Spells		<input type="checkbox"/>	<input type="checkbox"/>	Suicide																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Asthma		<input type="checkbox"/>	<input type="checkbox"/>	Neurologic Diseases such as																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Cough Up Phlegm		<input type="checkbox"/>	<input type="checkbox"/>	Migraine, Alzheimer's																																			
	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia		<input type="checkbox"/>	<input type="checkbox"/>																																				
	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis		<input type="checkbox"/>	<input type="checkbox"/>																																				
	<input type="checkbox"/>	<input type="checkbox"/>	Exposed to TB		<input type="checkbox"/>	<input type="checkbox"/>																																				
	<input type="checkbox"/>	<input type="checkbox"/>	Cough Up Blood		<input type="checkbox"/>	<input type="checkbox"/>																																				
	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatic Fever		<input type="checkbox"/>	<input type="checkbox"/>																																				
	<input type="checkbox"/>	<input type="checkbox"/>	Palpitations		<input type="checkbox"/>	<input type="checkbox"/>																																				
<input type="checkbox"/>	<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>																																						
<input type="checkbox"/>	<input type="checkbox"/>	Swollen Feet/Ankles	<input type="checkbox"/>	<input type="checkbox"/>																																						
<input type="checkbox"/>	<input type="checkbox"/>	Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>																																						
<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>																																						
<input type="checkbox"/>	<input type="checkbox"/>	Heart Murmurs	<input type="checkbox"/>	<input type="checkbox"/>																																						

Physician Signature _____

