

Patient Name: _____ DOB: _____

Age: _____

Previous Family Physician: _____

Reason for Your Visit: _____

How Long Have You Had Symptoms? _____

Past Medical History Circle which of the following you have or had: Please Specify

Diabetes/ Thyroid/ Endocrine Problems _____

Heart/ Vascular Problems _____

Lung Problems/ Asthma/ Pneumonia _____

Kidney or Urinary Problems _____

Liver Problems or Viral Hepatitis _____

Bleeding or Clotting Problems _____

Cancer or any Tumors _____

Neurologic/ Brain Problems/ Headaches _____

Depression/ Anxiety/ Psychiatric _____

HIV or AIDS _____

Osteoarthritis or Joint Problems _____

Rheumatoid Arthritis/ Lupus/ Autoimmune _____

Hearing or Vertigo Disorders _____

Gastroenterology Problems _____

Speech or Swallowing Disorders _____

Sinus/ Nasal/ Eye/ Facial Problems _____

Skin Disorders _____

Sleep Disorders/ Apnea/ CPAP _____

Past Surgical History List all surgeries you have had:

Surgery	Year of Surgery	Surgery	Year of Surgery
1.		2.	
3.		4.	

Family History

Circle which of the following run in your family: Please Specify:

Cancer or Benign Tumors _____

Diabetes, Thyroid, Endocrine Problems _____

Neurologic or Genetic Conditions _____

Lupus, Multiple Sclerosis, Autoimmune _____

Heart or Lung Problems _____

Allergies or Asthma _____

Blood Pressure Problems _____

Social History

Diet: good fair poor Exercise: yes no Frequency: _____ What: _____

Occupation/ what do you do for work? _____

Marital Status: Single Divorced Married Separated Significant Other Widowed

Caffeine Use: Never Daily Occasional

Tobacco/ Smoking: Never previous, date you quit? _____ Yes, I Smoke. How Often? _____

Alcohol Consumption: Daily 1-4 Times/Week Less Than 1 Time/Week Never

Recreational Drugs: Heroin or Opioids Cocaine Marijuana Never Other _____

Medications: (Include dosage, frequency and list all herbal, over-the-counter, & topical treatments.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

Drug Allergies: List drug and reaction: No Known Drug Allergies

