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Date of first appointment:_____

Name:_____ Date of Birth:_____Married yes no

Referred here by: (check one) ☐ Self ☐ Family ☐ Friend ☐ Doctor ☐ Other Health Professional

Name of person making referral:_____

The name of the person providing your primary medical care:_____

What is your chief complaint?
1.
2.
3.
4.

What is the history of your present illness?

Please list the names of other practitioners you have seen for this problem:_____

SYSTEMS REVIEW

As you review the following list, please check any of those problems which have significantly affected you.

Date of last mammogram_____/_____/_____ Date of last eye exam_____/_____/_____

Date of last chest x-ray_____/_____/_____ Date of last Tuberculosis test_____/_____/_____

Date of last bone densitometry_____/_____/_____ Date of last colonoscopy_____/_____/_____

Date of last prostate check_____/_____/_____

Constitutional
☐ Recent weight gain amount_____
☐ Recent weight loss amount_____
☐ Fatigue
☐ Weakness
☐ Fever

Eyes
☐ Pain
☐ Redness
☐ Loss of vision
☐ Double or blurred vision
☐ Dryness
☐ Feels like something in eye
☐ Itching eyes

Ears-Nose-Mouth-Throat
☐ Ringing in ears
☐ Loss of hearing
☐ Nosebleeds
☐ Loss of smell
☐ Dryness in nose
☐ Runny nose
☐ Sore tongue
☐ Loss of taste
☐ Dryness of mouth
☐ Frequent sore throats
☐ Hoarseness
☐ Difficulty in swallowing

Cardiovascular
☐ Pain in chest
☐ Irregular heart beat
☐ Sudden changes in heart beat
☐ High blood pressure
☐ High cholesterol
☐ Heart murmurs
☐ Heart failure
☐ Atherosclerotic heart disease
☐ Swollen legs or feet

Respiratory
☐ Shortness of breath
☐ Difficulty in breathing at night
☐ Cough
☐ Coughing of blood
☐ Wheezing (asthma)
☐ Pleurisy
☐ Tuberculosis

Gastrointestinal
☐ Nausea
☐ Vomiting of blood or coffee ground material
☐ Esophagitis/GERDs
☐ Heartburn
☐ Hepatitis
☐ Increasing constipation
☐ Persistent diarrhea
☐ Blood in stools or black, tarry stools
☐ Pancreatitis or gallbladder
☐ Diverticulitis
☐ Ulcer
☐ Crohn's disease or ulcerative colitis

Genitourinary
☐ Difficult urination
☐ Pain or burning on urination
☐ Blood in urine
☐ Pus in urine(cystitis)
☐ Discharge from penis/vagina
☐ Getting up at night to pass urine
☐ Vaginal dryness
☐ Rash/ulcers
☐ Sexual difficulties
☐ Prostate trouble

For Women Only
Age when periods began_____
Periods regular? ☐ Yes ☐ No
How many days apart?_____

Date of last period___/___/___

Date of last pap____/____/___

Bleeding after menopause?
☐ Yes ☐ No
Number of pregnancies_____

Number of miscarriages_____

Musculoskeletal

☐ Morning stiffness
Lasting how long?
_____minutes _____hours
☐ Joint pain
☐ Muscle weakness
☐ Muscle tenderness
☐ Joint swelling
☐ Back and neck problems
☐ Fibromyalgia

Integumentary (skin and/or breast)
☐ Easy bruising
☐ Redness
☐ Rash
☐ Hives
☐ Sun sensitive (sun allergy)
☐ Tightness
☐ Nodules/bumps
☐ Hair loss
☐ Color changes of hands or feet in the cold
☐ **Psoriasis**

Neurological System
☐ Headaches
☐ Dizziness
☐ Fainting or loss of consciousness
☐ Muscle spasm
☐ Difficulty in walking or speaking
☐ Sensitivity or pain of hands and/or feet.neuropathy
☐ Memory loss
☐ Night sweats

Endocrine
☐ Diabetes
☐ Thyroid disease
☐ Excessive thirst

Hematologic/Lymphatic
☐ Swollen,tender glands
☐ Anemia
☐ Bleeding tendency
☐ Blood Transfusion - year
☐ Easy clotting of veins or arteries

Allergic/Immunologic
☐ Frequent sneezing
☐ Increased susceptibility to infection
☐ Frequent sinus problems
☐ Eczema

Psychiatric
☐ Depression
☐ Anxiety
☐ Other uncomfortable emotion
☐ Any clinical diagnosis

MEDICATIONS

PRESENT MEDICATIONS (List any medications you are taking. Include such items as aspirin, vitamins, laxatives, calcium and other supplements, etc. Use a separate page if necessary.

Name of Drug	Dose (include strength & number of pills per day)	How long have you taken this medication	Please check: Helped? A Lot	Some	Not At All
1.			☐	☐	☐
2.			☐	☐	☐
3.			☐	☐	☐
4.			☐	☐	☐
5.			☐	☐	☐
6.			☐	☐	☐
7.			☐	☐	☐
8.			☐	☐	☐

PLEASE LIST ANY MEDICATIONS YOU ARE ALLERGIC TO, OR HAVE HAD A REACTION TO:

_____

Patient's Name:_____ Date:_____ Physician Initials:_____

PAST MEDICAL HISTORY

Do you know or have you ever had: (*check if "yes")*

☐ Cancer ☐ Heart Problems ☐ Asthma

☐ Cataracts/Glaucoma ☐ Diabetes

☐ Nervous breakdown ☐ Stomach Ulcers

☐ Rheumatic Fever ☐ Bad Headaches

☐ Neuropathy ☐ Jaundice ☐ Psoriasis

☐ Ulcerative Colitis/Crohn's Disease

☐ Kidney Disease ☐ Pneumonia

☐ HIV/AIDS ☐ Anemia or other blood disease

☐ Emphysema/Bronchitis ☐ Tuberculosis

Other significant illness:_____

_____

PAST SURGICAL HISTORY

TYPE	YEAR	REASON
1.		
2.		
3.		
4.		
5.		

Any serious injuries? ☐ Yes ☐ No

Describe:_____

FAMILY HISTORY:

	IF LIVING		IF DECEASED	
	Age	Health	Age at Death	Cause
Father				
Mother				

Number of Siblings_____ Number Living_____ Number Deceased_____

Number of Children_____ Number Living_____ Number Deceased_____

List ages of each child: _____

Health of children:_____

Do you know of any blood relative who has or had: (check and give relationship)

☐ Cancer_____ ☐ Heart disease_____ ☐ Rheumatoid arthritis_____ ☐ Tuberculosis_

☐ Psoriasis_____ ☐ Lupus_____ ____ ☐ Diabetes_____ ☐ Hepatitis

☐ Stroke_____ ☐ Bleeding tendency_____ ☐ Asthma_____ ☐ Spondylitis or colitis

SOCIAL HISTORY

Occupation_____

Do you drink caffeinated beverages? Cups/glasses per day?_____

Do you drink alcohol? ☐ Yes ☐ No. Number per week_____.

Do you exercise regularly? ☐ Yes ☐ No

Type_____ Amount per week_____ Do you smoke? ☐ Yes ☐ No

Past – How long ago?_____

Patient's Name:_____ Date:_____ Physician Initials:_____