Name:_____ **Age:**_____ **DOB:**_____ **Today's date**_____

Primary Care Physician_____ **Referring Physician**_____

Current problem/ reason for visit:_____

Weight_____ **Height**_____

Medications: Please list *all* prescription and over the counter medications.

If you do not take ANY medications please initial here (__)

IF YOU HAVE MORE THAN 8 MEDICATIONS PLEASE ASK FOR AN ADDITIONAL SHEET

Name/dose/frequency:	**Reason for taking:**
1._____	_____
2._____	_____
3._____	_____
4._____	_____
5._____	_____
6._____	_____
7._____	_____
8._____	_____

Medical Conditions: Check only boxes that apply to **you**. **If none initial here (_)**

(_) ADHD	(_) Chronic pain	(_) High Blood Pressure
(_) Allergies	(_) Depression	(_) High Cholesterol
(_) Anxiety	(_) Diabetes	(_) Insomnia
(_) Anesthesia Concerns	(_) Headache	(_) Sleep Apnea
(_) Asthma	(_) Heartburn/GERD	(_) Stroke
(_) COPD	(_) Heart disease	(_) Thyroid Disease
(_) HIV/Aids	(_) Tuberculosis	(_) Heart Attack
(_) Cancer_____	(_) Hepatitis, type_____	Other_____

Name:_____ Date_____Page 2

Allergies to Medications: **No known drug allergies (_)**

_____ _____

_____ _____

Social History: check all boxes that apply

Do you drink alcoholic beverages:

(_) Never (_) Occasionally (_) Moderately

Do you smoke or chew tobacco. Yes(_) No(_) Former(_) Packs/cans daily_____

Are you exposed to second hand smoke? (_) Yes (_) No

Family History: Please complete for **BLOOD** relatives only. **This section is not for the patient.** Please check all that apply.

	Mom	Dad	Brother	Sister	Son	daughter
Allergies						
Anesthesia concerns						
Arthritis						
Asthma						
Cancer(type)						
Childhood hearing loss						
Diabetes						
Heart Attack						
Heart Disease						
High Blood Pressure						
History free bleeding						
Stroke						
Thyroid						

Name:_____ Date:_____

Past Surgical History: Please list any surgeries major/minor. **None initial (_)**

_____ _____ _____

_____ _____ _____

_____ _____ _____

Review of Symptoms: Please check all that describe your current complaint

(_) Chest pain or discomfort

(_) Swelling in legs

(_) Fever

(_) Fatigue

(_) Heartburn/Acid reflux

(_) Nausea/Vomiting

(_) Seizures

(_) Difficulty Sleeping

(_) Changes in Vision

(_) Hearing loss

(_) Hoarse Voice

(_) Difficulty Swallowing

(_) Headache

(_) Snoring

(_) Nasal Drainage

(_) Nasal Congestion

(_) Wheezing

(_) Shortness of Breath

(_) Cough.

Annual Review Below:

****By signing below you are stating all the information on this form is correct.****

Date	Sign	Date	Sign