PATIENT'S NAME _____ **Birth Date:** _____

What medical problem(s) brings you to this office? _____

_____

How did you learn about our practice? _____

Who are your doctors? _____

_____

Do you have any *active* medical problems being treated by a Doctor? _____

_____

Do you have any *other* medical problems? _____

_____

What PRESCRIPTION medications do you take and why?

MEDICATION	BEING TAKEN FOR	MEDICATION	BEING TAKEN FOR

What other <u>non-prescription</u> (over-the-counter, herbal or homeopathic) medications do you take? _____

_____

_____

Pharmacy name: _____ **Phone #** _____

Please list any hospitalizations or surgeries (Please give date and reason).

Have you ever experienced any problems associated with general anesthesia during surgery? Yes_____ No _____

If yes, please describe _____

HOSPITALIZATION	REASON & DATE

Do you have any allergies to medications? Please list the names and type of reaction.

ALLERGIC TO	REACTION	ALLERGIC TO	REACTION

Do you have any environmental allergies? ( ) Yes ( ) No. To what? _____

_____**Have you ever been evaluated with allergy tests? ( ) Yes ( ) No**

<u>SOCIAL HISTORY:</u>

Occupation: _____

Do you smoke? ( ) NO ( ) YES How much? _____ packs per day.

Do you drink: Caffeinated beverages ? ( ) NO ( ) YES Alcohol? ( ) NO ( ) YES How much? _____

Do you live : ( ) Alone? ( ) With Spouse? ( ) With children? ( ) With friends? ( ) Assisted facility

CONTINUE ON OTHER SIDE

FAMILY HISTORY: Do any of your blood relations have problems with the following. Check any that apply:
( ) Asthma ( ) Diabetes ( ) Tuberculosis ( ) High Blood Pressure ( ) Stroke ( ) Headaches ( ) Hearing Loss...
( ) Heart Disease ( ) Allergies ( ) Cancer ( ) Thyroid Disease ( ) Bleeding Problems ( ) Problems with Anesthesia
( ) Autoimmune Disease

PAST MEDICAL HISTORY:
Have you ever been diagnosed with cancer? ( ) NO ( ) YES Please give details: _____

DO YOU HAVE PROBLEMS WITH ANY OF THE FOLLOWING? PLEASE CHECK (√) THOSE THAT APPLY

GENERAL	NO	( ) Fever ( ) Weight Change ( ) Fatigue
EYES	NO	( ) Visual Loss ( ) Glaucoma ( ) Cataracts ( ) Itchy Eyes ( ) Tearing ( ) Blurred Vision
EARS	NO	( ) Vertigo ( ) Dizziness ( ) Ringing Noises ( ) Hearing Loss ( ) Hearing Aid ( ) Infections ( ) Trauma ( ) Noise Exposure ( ) Ear Ache ( ) Drainage
NOSE	NO	( ) Discharge ( ) clear, ( ) colored, ( ) thick, ( )thin] ( ) Post Nasal Drip ( ) Obstruction ( ) Bleeding ( ) Sneezing
MOUTH	NO	( ) Lumps ( ) Dental Problems ( ) Tonsillitis ( ) Mouth Sores
THROAT	NO	( ) Hoarseness ( ) Voice Change ( ) Problem Swallowing ( ) Pain
NECK	NO	( ) Pain ( ) Lumps ( ) Thyroid Nodules ( ) Swollen Glands
SKIN	NO	( ) Breast Lumps ( ) Psoriasis ( ) Skin Growths ( ) Rash ( ) Itching
LUNGS	NO	( ) Wheezing ( ) Asthma ( ) COPD ( ) Bronchitis ( ) Emphysema ( ) Coughing Up Blood ( ) Chronic Cough ( ) Pneumonia ( ) Positive TB Test ( ) Shortness of Breath
SLEEPING	NO	( ) Snoring ( ) Apnea ( ) Insomnia ( ) Waking Up Tired ( ) Daytime Tiredness
HEART	NO	( ) High Blood Pressure ( ) Coronary Artery Disease ( ) Myocardial Infarction ( ) Chest Pain ( ) Mitral Valve Prolapse ( ) Congestive Heart Failure ( ) Heart Valve Disease ( ) Angina ( ) Murmurs ( ) Rheumatic Fever
GASTRO-INTESTINAL	NO	( ) Hiatal Hernia ( ) Heartburn ( ) Reflux ( ) Rectal Bleeding ( ) Ulcers ( ) Hepatitis Type __ ( ) Jaundice ( ) Nausea ( ) Vomiting ( ) Colitis
GENITO-URINARY	NO	( ) Frequent Urination ( ) Pain ( ) Discharge ( ) Incontinence ( ) Bloody Urine **MEN**: ( ) Prostate Problem ( ) Hernias **WOMEN**: ( ) Abnormal Periods ( ) Menopause ( ) **Are You Pregnant**? ( ) Y ( ) N
MUSCLE / JOINTS	NO	( ) Muscle Pain ( ) Back Pain ( ) Joint Pain ( ) Arthritis ( ) Lupus ( ) Gout
NEUROLOGICAL	NO	( ) Headaches ( ) Migraines ( ) Imbalance ( ) Alzheimer's Disease ( ) Loss of Consciousness ( ) Parkinson's Disease ( ) Head Trauma ( ) Tremors ( ) Fainting ( ) Seizures ( ) TIA's ( ) Stroke
PSYCHIATRIC	NO	( ) Nervousness ( ) Anxiety ( ) Depression ( ) Mood Swings
ENDOCRINE	NO	( ) Thyroid Disease ( ) Diabetes ( ) Glandular/Hormonal Problems
HEMATOLOGIC	NO	( ) Slow to Heal After Cuts ( ) Easy Bruising or Bleeding ( ) Immunocompromised Status ( ) Transfusions ( ) Phlebitis ( ) Anemia

If this form is filled out by anyone other than the patient, please write the name and relationship.

NAME: _____ RELATIONSHIP TO PATIENT: _____

I certify that this information is true and correct to the best of my knowledge. I will notify you if any changes occur/

SIGNATURE: _____ DATE: _____

I have reviewed the above information with the patient: MD SIGNATURE :_____