

Today's Date _____

First Name _____ Last Name _____ Age _____ Date of Birth _____

Primary Medical Provider _____ Location of Clinic _____

Pharmacy _____ Location _____

• **PERSONAL MEDICAL HISTORY:** *(Please circle conditions that have been diagnosed or treated)*

- | | | |
|---------------------|-------------------------------|-----------------------------|
| Anemia | Coronary artery disease | Kidney disease |
| Anxiety disorder | Deep vein thrombosis | Kidney stone |
| Arthritis | Depression | Liver disease |
| Asthma | Diabetes | Pulmonary embolism |
| Autoimmune disorder | Diverticulosis | Reflux/GERD |
| Bleeding disorder | Gout | Seizure/Epilepsy |
| Bronchitis | Headaches | Stroke |
| COPD | Heart disease | Tuberculosis |
| Cancer(s) _____ | Hepatitis | Postmenopausal |
| _____ | High cholesterol | Female: Date of last period |
| _____ | High blood pressure | _____ |
| _____ | Thyroid disorder | |
| | (hypothyroid or hyperthyroid) | |

• **PREVIOUS SURGERIES AND PROCEDURE:** *(Please list the date)*

- | | |
|---------------------------------|-------|
| Tonsillectomy | _____ |
| Appendectomy | _____ |
| Hysterectomy (partial or total) | _____ |
| EGD | _____ |
| Colonoscopy | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

• **FAMILY HISTORY:** **RELATIONSHIP:**

- | | |
|---------------------|-------|
| Heart disease | _____ |
| Diabetes | _____ |
| Colon cancer | _____ |
| Breast cancer | _____ |
| Stroke | _____ |
| High blood pressure | _____ |

- **SOCIAL HISTORY:** *(Please circle which applies)*

Employed Unemployed Retired Work requirement: Heavy lifting or No heavy lifting
Smoking status: Smoker or Nonsmoker How many years _____ Quit when _____
Alcohol: None Occasional Moderate Daily

- **MEDICAL ALLERGIES:** *(Please list the medicine and type of reaction)*

No Known Drug Allergies

- **REVIEW OF SYSTEMS:** *(Please circle which applies)*

General: weight loss weight gain fatigue normal activity level
Cardio: Rest chest pain Chest pain with exertion
Eyes: blurred vision eye pain
Auditory: loss of hearing ear pain
Breasts: breast lump nipple discharge
GI: difficulty swallowing abdominal pain nausea vomiting
 constipation dark blood in stool bright red blood in stool
Urinary: pain with urination difficulty with urination increase frequency
Skeletal: soft tissue swelling up or lump decreased range of motion joint swelling
Vascular: cramps in thighs/calves when walking non-healing ulcers in feet
Skin: abnormal rash change in mole(s) skin growth
Neuro: seizure stroke numbness weakness insomnia
Psychiatric: depression anxiety
Endocrine: temperature intolerance thyroid enlargement
Allergies: sneezing runny nose hives
Immune: chronic fever enlarged lymph glands
Female: heavy periods vaginal discharge

- **MEDICINES** *(Please list all current medications and dosage or attach a list)*
