

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Current Problem: \_\_\_\_\_

Drug Allergies: \_\_\_\_\_

Other Allergies: \_\_\_\_\_

Medical Conditions: Do you now have or have had in the past?

please circle your answer:

Diabetes Mellitis	yes	no	Hepatitis	yes	no
Hypertension	yes	no	Gallstone	yes	no
Bleeding Abnormality	yes	no	Cirrhosis	yes	no
Kidney Disease	yes	no	Mitral Prolapsed	yes	no
COPD/Emphysema	yes	no	Arrhythmia	yes	no
Asthma	yes	no	Coronary Artery Disease	yes	no
Bronchitis	yes	no	Cancer	yes	no
Hyperthyroid	yes	no	type _____		
Hypothyroid	yes	no	Convulsions	yes	no
HIV	yes	no			

Medications: including aspirin and blood thinners: please list:

Previous Surgeries: please list:

**Social History:**

Use of Tobacco    yes    no    amount \_\_\_\_\_ previously, but quit    yes    no  
Use of Alcohol    never    rarely    moderate    daily  
Uses of Drugs    yes    no    type: \_\_\_\_\_

**Family History:**    age    disease    if deceased, cause of death

Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
Children	_____	_____	_____

**Review of Symptoms:**

Do you have any of the following? Please circle your answer.

Chills	yes	no	Chest Pain	yes	no
Fevers	yes	no	Palpitations	yes	no
Night Sweats	yes	no	Abdominal Pain	yes	no
Coughs	yes	no	Blood in Urine	yes	no
Shortness of Breath	yes	no	Painful Urination	yes	no
Nausea/Vomiting	yes	no	Blood in Stool	yes	no
Weakness	yes	no	Weight Loss	yes	no

**For Women:** Last Menstrual Period: \_\_\_\_\_ Last Pelvic Exam: \_\_\_\_\_

Are you pregnant?    yes    no    term: \_\_\_\_\_