Patient #: _____

Patient Name: _____

CURRENT MEDICATIONS, VITAMINS AND HERBAL SUPPLEMENTS

Medication	Strength	Number of pills taken & frequency	Medication	Strength	Number of pills taken & frequency
Example: Tylenol	500 mg	1- Twice daily			

ALLERGIES OR INTOLERANCE TO FOOD OR MEDICATION

Medication/Food	Reaction	Medication/Food	Reaction

PAST MEDICAL HISTORY

Condition/Disease	**Year Began**	**Condition/Disease**	**Year Began**
□ Anxiety		□ Heart Problems -	
□ Arthritis		□ High Cholesterol	
□ Asthma		□ Hypertension	
□ COPD, Emphysema, or Asthma		□ Hyperthyroidism (low thyroid)	
□ Cancer		□ Kidney Disease/ Kidney Stones	
□ Coronary Artery Disease		□ Liver Disease	
□ Depression		□ Reflux/GERD	
□ Diabetes		□ Stroke	
□ Other:			

PAST SURGICAL PROCEDURES/ HOSPITALIZATIONS/ SERIOUS INJURIES OR FRACTURES

Operation/ Hospitalization/Injury	Mo/Year	Operation/ Hospitalization/Injury	Mo/Year

FAMILY HEALTH HISTORY

Relative	Living/Deceased	Current age or age at death	Cause of death	Health Problems
Father:				
Mother:				
Brother(s):				
Sisters(s):				

SOCIAL AND WORK HISTORY

Occupation: _____ Highest level of education: _____

Exercise Level: □ None □ Occasional □ Moderate □ Heavy

General Stress Level: □ Low □ Medium □ High

Smoking Status: □ Never Smoker □ Former Smoker □ Current Every day Smoker □ Current Some day Smoker

If Smoking – How much? _____

Alcohol Intake: □ None □ Occasional □ Moderate □ Heavy

Caffeine Intake: □ None □ Occasional □ Moderate □ Heavy

REVIEW OF SYSTEMS – PLEASE CIRCLE THE FOLLOWING SYMPTOMS THAT ARE A PROBLEM FOR YOU

Vision problems	Wheezing	Lumps in breast	Frequent Urination	Excessive hunger
Hearing problems	Asthma / COPD	Breast discharge	Incontinence	Excessive thirst
Sinus trouble	Emphysema	Trouble swallowing	Blood in Urine	Weakness
Hay fever	Bronchitis	Nausea	History of STD's	Fatigue
Nosebleeds	TB exposure	Vomiting	Anemia	Fever / Sweating
Sore throat	Chest pain	Abdominal pain	Easy bruising	Fainting
Hoarseness	Chest discomfort	Hepatitis / Jaundice	Pain in legs	Seizures / Tremor
Lumps in neck	Shortness of breath	Gallstones	Joint pain / stiffness	Headaches
Tooth problems	High blood pressure	Diarrhea	Blood clot	Numbness/tingling
Cough	Diabetes	Constipation	Weight loss / gain	Anxiety/Depression
Coughing blood	High cholesterol	Blood in stool	Heat/cold intolerance	Difficulty sleeping

Screening History

SCREENING	Tested Date	VACCINATION & Immunization	Tested Date
Urinalysis	___ /____ /_____	Influenza vaccination	___ /____ /_____
Annual Lab Tests (CBC, CMP, Lipid, TSH+T4)	___ /____ /_____	B Hepatitis Vaccination	___ /____ /_____
B/C hepatitis	___ /____ /_____	Pneumonia vaccination	___ /____ /_____
Endoscopy	___ /____ /_____	T-D (Tetanus) vaccination	___ /____ /_____
Colonoscopy	___ /____ /_____	Shingles vaccination	___ /____ /_____
Mammography	___ /____ /_____		
Pap smear	___ /____ /_____		
Osteoporosis Screening (Bone Density/ DEXA scan)	___ /____ /_____		