

Patient Name: _____ Age: _____ Appt. Date: _____

Weight: _____ Height _____

Describe your main problem? _____

How long have you had this problem? _____

List all other symptoms _____

Please do not write in this space

Medication Allergies
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

Have you ever had the following?
Diabetes.....Yes No
Hypertension.....Yes No
Cancer.....Yes No
Stroke.....Yes No
Heart trouble.....Yes No
Reflux symptoms.....Yes No
Bleeding tendency....Yes No
Hepatitis.....Yes No
HIV or Exposure.....Yes No
Lung problems.....Yes No

List Surgeries/ Past & Present Illnesses/ Serious Injuries When?

List Medications you are currently taking and Dosage:
1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____

Patient Social History
Occupation: _____
Marital Status: ___ Single ___ Married ___ Separated ___ Divorced ___ Widowed
Use of Alcohol: ___ Never ___ Rarely ___ Moderate ___ Daily _____
Use of tobacco: ___ Never ___ Previously but quit ___ Current packs per day _____

Family Medical History

	Age	Diseases	If Deceased, Cause of Death
Father	_____	_____	_____
Mother	_____	_____	_____
Siblings	_____	_____	_____
	_____	_____	_____

PATIENT SIGNATURE _____