Date of Appointment: ________________

Patient Name: ______________________________ D.O.B.___________ Date: ___________

Please check conditions you have had?

GENERAL
- ☐ Serious Infection (e.g. pneumonia) ________
- ☐ Diabetes Mellitus
- ☐ Rheumatic Fever
- ☐ HIV Infection
- ☐ Cancer (Where?) _______ ______________________

CVS
- ☐ High Blood Pressure
- ☐ Congestive Heart Failure
- ☐ Heart Murmur
- ☐ Heart Valve Disease
- ☐ Angina
- ☐ Heart Attack
- ☐ High Cholesterol
- ☐ Abnormal Heart Rhythm
- ☐ Blocked Arteries in Neck
- ☐ Blocked Arteries in Leg
- ☐ Blood Clot in Leg (DVT)

HEENT
- ☐ Glaucoma
- ☐ Allergies 'hay fever'
- ☐ Frequent Ear Infections
- ☐ Frequent Sinus Infections

RESPIRATORY
- ☐ Asthma
- ☐ Emphysema
- ☐ Blood Clots in Lung
- ☐ Sleep Apnea

MUSCULOSKELETAL/ EXTREMITIES
- ☐ Osteoporosis
- ☐ Rheumatoid Arthritis
- ☐ Degenerative Joint Dis
- ☐ Fibromyalgia
- ☐ Neck Pain (Herniated Disc)
- ☐ Back Pain (Herniated Disc)

LYMPHATIC/HEMATOLOGIC
- ☐ Thyroid Goiter
- ☐ Over Active Thyroid
- ☐ Under Active Thyroid
- ☐ Transfusions
- ☐ Anemia

GI/GU
- ☐ Stomach Ulcers
- ☐ Ulcerative colitis
- ☐ Chrons Disease
- ☐ Bleeding from Intestines
- ☐ Diverticulitis
- ☐ Colon Polyps
- ☐ Irritable Bowel Disease
- ☐ Hepatitis
- ☐ Cirrhosis of the liver
- ☐ Liver Failure
- ☐ Pancreatitis
- ☐ Gallstones
- ☐ Kidney Stones
- ☐ Kidney Failure
- ☐ Prostate Disease
- ☐ Endometriosis
- ☐ Abnormal Pap Smear
- ☐ Sex Transmitted Disease

SKIN/BREAST
- ☐ Acne
- ☐ Eczema
- ☐ Psoriasis
- ☐ Fibrocystic Breast Disease

NEUROLOGIC/PSYCHIATRIC
- ☐ Chronic Vertigo (Meniere's)
- ☐ Peripheral Nerve Disease
- ☐ Migraine Headaches
- ☐ Stroke
- ☐ Depression
- ☐ Anxiety

Other:____

Please indicate any surgeries you have had and the year you had them:

Year		Year		Year		Year	
_____	Angioplasty	_____	Trauma Related Surgery	_____	Stomach Surgery	_____	C-Section
_____	Carotid Artery Surgery	_____	Back or Neck Surgery	_____	Inguinal Hernia	_____	Ovary Removed
_____	Other Vascular Surgery	_____	Hip Surgery	_____	Gallbladder	_____	Hysterectomy
_____	Coronary Bypass	_____	Knee Surgery	_____	Appendectomy	_____	Breast Surgery
_____	Chest / Lung Surgery	_____	Carpal Tunnel Surgery	_____	Prostate Surgery	_____	Tubal Ligation
_____	Tonsillectomy	_____	Sinus Surgery	_____	Bladder Surgery		
_____	Neurosurgery	_____	Ear Surgery	_____	Thyroid Surgery		

Other: ____

Please indicate when and where you last had any of the following preventative tests or services:

Year		**Where**	**Year**		**Where**
_____	Cardiac Angiogram	________________	_____	Colonoscopy	________________
_____	Stress Test	________________	_____	Rectal Exam	________________
_____	Echocardiogram	________________	_____	Colon CA Stool Test	________________
_____	Chest X-Ray	________________	_____	Flexible Sigmoid	________________
_____	EKG	________________	_____	Barium Enema	________________
_____	Bone Density Test	________________	_____	Mammogram	________________
_____	Prostate CA Blood Test	________________	_____	Breast Exam	________________
_____	Flu Vaccine	________________	_____	Physical Exam	________________
_____	Pneumonia Vaccine	________________	_____	Pap Smear	________________
_____	Tetanus Vaccine	________________	_____	ABI	________________
_____	Hepatitis Vaccine	________________	_____	Eye Exam	________________

Patient Name: ____________________________________ *D.O.B.*_____________ *Date:* ___________

Please indicate any specialists you currently see (Name & Specialty):

____ ____

____ ____

Please indicate any allergies or intolerance to drugs or other substances:

____ ____

____ ____

Please list the medications currently taken, their dosages, and how many times per day you take them:
(You may also attach your medication list)

____ ____

____ ____

Name/Address/Phone # of preferred Pharmacy: ____

Family Medical History - Please check any major illness in your family members (Mother, Father, Siblings only):

□ Tuberculosis ____	□ Diabetes Mellitus ____	□ Epilepsy ____
□ Emphysema ____	□ Thyroid Disease ____	□ Neurologic Disorder ____
□ Heart Disease ____	□ Anemia ____	□ Liver Disease ____
□ High Blood Pressure ____	□ Hemophilia ____	□ Breast Cancer ____
□ Osteoporosis ____	□ Kidney Disease ____	□ Ovarian Cancer ____
□ Colon Cancer ____	□ Prostate Cancer ____	

Other: ____

Is your Mother Living? ______ If no, Age of Death: _____ Is your Father Living? _____ If no, Age of Death: ______

Personal History - Please write in or circle the information that applies to you:

Occupation: ___________________________________

Education	Sexually Active	Sexuality	Marital Status	Living Status	Diet	Exercise	Alt Medicine
Primary	Yes	Heterosexual	Single	Alone	None	None	Holistic
Secondary	No	Homosexual	Married	With Spouse	Low Fat	Walking	Chiropractic
College		Bi-Sexual	Divorced	With Parents	Low Chol	Aerobics	Homeopathy
Post Grad		Transgender	Widowed	Assisted Living	Low Carb	Weightlifting	Acupuncture
Doctorate			Separated	Nursing Home	Vegetarian	____Dys/wk	Herbal

Tobacco	Alcohol	Illicit Drugs	Caffeine
Never / past / active	Never / past / active	Never / past / active	Never / past / active
Cigarette / cigar / pipe	Liquor / wine / beer	cocaine / marijuana	Coffee / tea / soda
Snuff / dip / chewing	____ drinks per	heroin / amphetamine	____cans / cups per day
Start ______ Stop______	day / week / month	barbiturate / LSD / PCP	
Packs per day _______	AA / Alcohol Rehab	IV drug abuse / Drug Rehab	

Patient Name: ___________________________________ *D.O.B.*_____________ *Date:* ___________

Yes	No	IN THE PAST YEAR, HAVE YOU HAD:
		Any sudden loss of weight or weight gain, which you cannot explain?
		Unusual sensitivity to hot or cold?
		Any loss of consciousness?
		Any seizures or headaches?
		Any sudden changes in vision, loss of vision, double vision?
		Any loss of hearing or persistent ringing in the ear?
		Any problems chewing and swallowing food?
		Any particular foods that bother you?
		Do you have symptoms of heart burn or acid reflux?
		Any changes in stool habits such as blood in stools, black tarry stools, constipation or diarrhea?
		Any changes in urine habits, blood in urine, or burning with urination?
		Do you often wake up at night to urinate? ______ times per night.
		Are you bothered by chronic cough or shortness of breath?
		Any history of asthma or wheezing?
		Any chest pains or palpations?
		Do you wake up short of breath?
		Any leg swelling?
		Any arm or leg weakness?
		Any cramps or numbness?
		Have you had feelings of depression; feeling "blue", tearful, or sad?
		Do you have trouble falling asleep, staying asleep, or waking up early?
		Do you have problems with excessive worry, persistent worry, or difficulty controlling your worries?

FOR WOMEN ONLY:

Last Menstrual period ________________ Any abnormal bleeding or vaginal discharge? _________

# of Pregnancies ______ # of Children ______

FOR MEN ONLY:

Do you have a problem with erectile dysfunction? ___________ # of Children ______

Have you recently gone anywhere else for healthcare? (Health Fair, 24 hour Clinic, or Hospital Emergency Room)
If so, Please indicate when and where:

Does anyone come to your house to give health care (Nurse or Therapist)?

Physician Only: ☐ *Scan Document*

Please check if you have the following paperwork to add to your medical record:

☐ DNR ☐ Durable Power of Attorney ☐ Living Will ☐ Advanced Directives