Patient Name: _____ **Date:** _____

Date of Birth: _____ **Age:** _____ **Weight:** _____ **Height:** ____'____"

What is your reason for visit? _____

Date symptoms began? _____

Severity of symptoms: ☐ **Mild** ☐ **Moderate** ☐ **Severe** ☐ **Incapacitating**

Aggravated by: _____

Relieved By: _____

How many times have you been treated for the problem? _____

List full names & locations of physicians who have treated you for this condition: _____

Have you taken any aspirin or ibuprofen products (Advil, Aleve, etc.) during the past month? Y / N

If yes, what did you take? _____ **When?** _____ **For how long?** _____

Are you taking it now? Y / N

Symptoms Check (✓) symptoms you currently have or have had in the past year.

Constitutional
- ☐ Chills
- ☐ Fatigue
- ☐ Fever
- ☐ Weight loss
- ☐ Weight gain
- ☐ Night sweats
- ☐ Weakness

Respiratory
- ☐ Sleep apnea
- ☐ Shortness of breath
- ☐ Snoring
- ☐ Wheezing
- ☐ Cough

Cardiovascular
- ☐ Chest pain
- ☐ Heart murmur
- ☐ Palpitations
- ☐ Heart problems

Metabolic/Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance
- ☐ Excessive thirst

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn or acid reflux
- ☐ Vomiting
- ☐ Nausea

Genitourinary
- ☐ Change in urine color
- ☐ Kidney problems
- ☐ Painful urination
- ☐ Frequent urination

Neurological
- ☐ Difficulty falling asleep
- ☐ Difficulty staying asleep
- ☐ Excessive daytime sleepiness
- ☐ Non-restorative sleep
- ☐ Numbness in legs or arms
- ☐ Blackouts or fainting
- ☐ Tingling
- ☐ Tremor
- ☐ Weakness
- ☐ Headaches
- ☐ Seizures
- ☐ Confusion or memory loss

Psychiatric
- ☐ Anxiety
- ☐ Depression
- ☐ Hallucinations
- ☐ Nervousness or increased stress

Dermatologic
- ☐ Skin rash

Musculoskeletal
- ☐ Back pain
- ☐ Bone/joint symptoms
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Neck stiffness
- ☐ Rheumatologic symptoms

Immunological
- ☐ Hay fever
- ☐ Hives
- ☐ Chemical sensitivity
- ☐ Environmental allergies
- ☐ Food allergies/sensitivity

HEENT

Head/Eyes

- ☐ Headache
- ☐ Burning eyes
- ☐ Double vision
- ☐ Discharge from eyes
- ☐ Dry eyes
- ☐ Feeling of something in the eye(s)
- ☐ Sensitivity/pain of eyes to light
- ☐ Redness of the eye(s)
- ☐ Itchy eye(s)
- ☐ Nystagmus
- ☐ Eye pain
- ☐ Scotoma
- ☐ Eye Floaters
- ☐ Tearing
- ☐ Loss of vision

Ears

- ☐ Ear discharge
- ☐ Excessive ear wax
- ☐ Fullness in ears
- ☐ Hearing loss
- ☐ Frequent ear infections
- ☐ Ear pain
- ☐ Tinnitus or ringing in the ears
- ☐ Vertigo
- ☐ Excessive noise exposure

Nose/Sinus

- ☐ Reduced sensation of smell
- ☐ Nasal drainage
- ☐ Nose bleed
- ☐ Facial pain
- ☐ Nasal congestion
- ☐ Nasal obstruction
- ☐ Runny nose
- ☐ Sinusitis
- ☐ Sneezing

Mouth/Throat

- ☐ Change in taste
- ☐ Voice change
- ☐ Cold sores
- ☐ Difficulty swallowing
- ☐ Hoarseness
- ☐ Lump in throat
- ☐ Mouth sores
- ☐ Pain when swallowing
- ☐ Post nasal drip
- ☐ Tongue soreness
- ☐ Sore throat/pharyngitis
- ☐ Snoring
- ☐ Tooth pain

Neck

- ☐ Lumps in neck
- ☐ Swollen glands in neck
- ☐ Pain in neck

Other:

_____

_____

_____

_____

_____

Conditions Check (✓) conditions you currently have or have had in the past year.

Past medical History

- ☐ Allergies
- ☐ Anemia
- ☐ Angina
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Atrial Fibrillation
- ☐ Benign Prostaic Hypertrophy
- ☐ Blood Clots
- ☐ COPD
- ☐ Coronary Artery Disease
- ☐ Crohn's Disease
- ☐ Depression
- ☐ Diabetes
- ☐ Gall Bladder Disease
- ☐ GERD
- ☐ Hepatitis C
- ☐ Hyperlipidemia
- ☐ Hypertensions
- ☐ Irritable Bowel Diseases
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Myocardial Infarction
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Peptic Ulcer Disease
- ☐ Renal Disease
- ☐ Seizure
- ☐ Thyroid Disease

Other: _____

_____

_____

Past Surgical Histories *(with approximate dates)*

Other: _____

_____

_____

Family History

Who: What Condition: Age of Onset: Cause of death?

_____

_____

_____

_____

_____

Social History

Tobacco Use: ☐Yes ☐No ☐Former
Type: _____
Packs/amount per day: _____
Years Smoked: _____
Year Quit: _____

Drinks Alcohol: ☐Yes ☐No ☐Formerly Year Quit: _____
Type: _____ Frequency: _____
Amount: _____ Last Drink:_____

Caffeine Use:
Type: _____ Amount daily: _____

How much water do you drink in a day?

_____

Occupation:
Employer: _____ Occupation: _____
Employment status: _____ Restrictions: _____

Medications

List all prescription and over-the-counter medications and their dosages you are currently taking- **please ensure that spelling is correct**

_____ _____
_____ _____
_____ _____
_____ _____

Drug Allergies, Severity & Reaction

_____ _____
_____ _____
_____ _____

Preferred Pharmacy: _____ Phone: _____

To the best of my knowledge the above information is complete and correct. I understand that reporting incomplete or inaccurate information can be dangerous to my health. I understand that I am solely responsible for any error or omissions that I may have made in the completion of this form. I understand that it is my responsibility to inform my doctor if I or my minor child ever have a change in health.

_____ _____
Signature of patient, parent, guardian, or personal representative Date

_____ _____
Please print name of patient, parent, guardian, or personal representative Date

_____ _____
Reviewed by Date

Consent to Obtain Medication History

Our medical practice has adopted an electronic medical record system in order to improve the quality of our services. This system also allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer.

An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions.

By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose, information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health conditions, such as depression. This information will become part of your medical record.

This medication history is a useful guide, but it may not be completely accurate. Some pharmacies do not make drug history available to us, and the drug history from your health plan might not include drugs that you purchased without using your health insurance. Your medication history might not include over the counter medicines, supplements or herbal remedies. It is still very important for us to take the time discuss everything you are taking, and for you to point out to us any errors in your medication history.

I give permission for you to obtain my medication history from my pharmacy, my health plans and my other healthcare providers.

Patient's Name _____ Date _____

Patient's Signature _____ Date _____

- -

If patient is a Minor :

Signature of parent or legal guardian _____ Date _____