Patient Name:________________________________ Date Of Birth:_________ Primary Physician:________________

Referring Physician: _____________________ Reason for your visit today?____________________________________

LIST ALL ALLERGIES (medications, foods, and other substances – please list reaction.)

Allergies	Type of Reaction		Allergies	Type of Reaction

LIST ALL MEDICATIONS YOU ARE TAKING (prescription, over-the-counter, vitamins or herbal) ☐ **None**

Medication	Dosage	How often taken		Medication	Dosage	How often taken

PREFERRED PHARMACY NAME (include address if known)
____

Past Medical History: Check all that apply

☐ High Blood Pressure
☐ Heartburn/Reflux
☐ Asthma/COPD
☐ Irregular Heart Beat
☐ High Cholesterol
☐ Cancer:____________
☐ Anemia
☐ Anxiety/Depression
☐ Cataracts/Glaucoma
☐ Thyroid dysfunction
☐ Pneumonia
☐ Diabetes
☐ Sleep Apnea
☐ Heart Disease
☐ Stroke
☐ Arthritis
☐ Allergies
☐ Migraines/Headaches
☐ Pregnancy
☐ Chronic ear infection
☐ Chronic sinusitis
☐ Other:_____________

Past Surgical History: Check all that apply

☐ Tonsillectomy
☐ Cesarean Section
☐ Hysterectomy
☐ Gallbladder
☐ Joint Surgery:_______
☐ Heart Surgery:______
☐ Tubal Ligation
☐ Intestinal:__________
☐ Pacemaker
☐ Thyroidectomy
☐ Other:_____________
☐ Wisdom tooth removal
☐ Angioplasty/Stent
☐ Appendectomy
☐ Cataract
☐ Vasectomy
☐ Ear Surgery:________
☐ Nasal/Sinus:________
☐ Plastic Surgery:_____
☐ Defibrillator
☐ Brain/Spine Surgery:
____

Family History: Check all that apply and include their relationship to you

☐ Allergies:___________
☐ Anesthesia Reactions:__
☐ Cancer:____________
☐ Diabetes:___________
☐ Hearing Loss:_______
☐ Migraines:__________
☐ Asthma:____________
☐ Bleeding Problems:_____
☐ Depression:_________
☐ Heart Disease:______
☐ Kidney Disease:_______
☐ Other:_____________

Social History: Check all that apply

Tobacco use: ☐ **Yes** ☐ **No** Type:________________
Desire to Quit: ☐ **Yes** ☐ **No**
Former smoker: ☐ **Yes** ☐ **No**
Second hand smoke: ☐ **Yes** ☐ **No**
Alcohol Use: ☐ **Yes** ☐ **No**
History of alcoholism: ☐ **Yes** ☐ **No**
Frequency of alcohol use: ☐ **Daily** ☐ **Weekly** ☐ **Rare**
Caffeine use: ☐ **Yes** ☐ **No** Type:_______________
Other Drug use: ☐ **Yes** ☐ **No** Type:_______________
Occupation: ______________________
Marital Status: ☐ S ☐ M ☐ D ☐ W

Review of Systems: check symptoms that have recently occurred

GENERAL: ☐ fatigue, ☐ night sweats, ☐ fever, ☐ weight loss
EYE: ☐ double vision, ☐ itchiness, ☐ redness, ☐ loss of vision
EAR: ☐ drainage, ☐ hearing loss, ☐ dizziness, ☐ ringing, pain
NOSE: ☐ congestion, ☐ bleeding, ☐ loss of smell, ☐ runny nose
THROAT: ☐ pain, ☐ problems swallowing, ☐ voice changes ☐ dry mouth
HEART: ☐ murmur, ☐ chest pain, ☐ ankle swelling
LUNG: ☐ cough, ☐ wheezing, ☐ shortness of breath
GI: ☐ abdominal pain, ☐ diarrhea, ☐ heartburn, ☐ nausea
GU: ☐ infections, ☐ stones, ☐ difficulty urinating
ENDOCRINE: ☐ heat/cold intolerance, ☐ extra hair growth
SKELETAL: ☐ joint swelling/pain, ☐ muscle pain, ☐ fracture
SKIN: ☐ rash, ☐ easy bruising, ☐ pigment changes, ☐ itchiness
NEURO: ☐ headaches, ☐ seizures, ☐ weakness, ☐ numbness