Name: _____

Describe your symptoms or complaints:

Is your problem due to an accident? ❑ Yes ❑ No Describe your accident:

Are you under another Doctor's care? ❑ Yes ❑ No	
Dr's name:	For what reason?
Dr's name:	For what reason?
Dr's name:	For what reason?

What drugs are you allergic to?

What medicines do you take for your present problem? Dosage	What other medicines or drugs do you take? Dosage
1.	1.
2.	2.
3.	3.
4.	4.
5.	5.

What operations have you had? When?	Operations? When?
1.	6.
2.	7.
3.	8.
4.	9.
5.	10.

How much do you smoke? _____
What do you smoke? _____
When did you quit smoking? _____

How much alcohol do you drink? _____
What alcohol do you drink? _____
When did you quit drinking? _____

DO YOU HAVE OR HAVE YOU HAD THESE CONDITIONS? Name: _____

	Yes	No
CONSTITUTIONAL		
Arthritis/gout	☐	☐
Recent weight change	☐	☐
Insomnia	☐	☐
Fatigue	☐	☐
Cancer	☐	☐
HIV/AIDS	☐	☐
Hepatitis	☐	☐
Tuberculosis (TB)	☐	☐
EYES		
Eye disease or injury	☐	☐
Wear glasses/contact lens	☐	☐
Blurred or double vision	☐	☐
Glaucoma	☐	☐
EAR/NOSE/MOUTH/THROAT		
Hearing Loss	☐	☐
Ringing	☐	☐
Sinus problem	☐	☐
Voice change	☐	☐
Swollen glands in neck	☐	☐
CARDIOVASCULAR		
Heart trouble	☐	☐
Chest pain or angina	☐	☐
Palpitation	☐	☐
Shortness of breath	☐	☐
Hypertension	☐	☐
NEUROLOGICAL		
Frequent or recurring headaches	☐	☐
Light headed or dizzy	☐	☐
Convulsions or seizures	☐	☐
Memory loss or confusion	☐	☐
Tremors	☐	☐
Paralysis	☐	☐
Stroke	☐	☐
Head Injury	☐	☐
PSYCHIATRIC		
Nervousness	☐	☐
Depression	☐	☐
Anxiety	☐	☐
ENDOCRINE		
Glandular or hormone problem	☐	☐
Thyroid disease	☐	☐
Diabetes	☐	☐
RESPIRATORY		
Chronic or frequent coughs	☐	☐
Spitting up blood	☐	☐
Shortness of breath	☐	☐
Asthma or wheezing	☐	☐
GASTROINTESTINAL		
Loss of appetite	☐	☐
Rectal bleeding or blood in stool	☐	☐
Abdominal pain or heartburn	☐	☐
Peptic ulcer (stomach or duodenal)	☐	☐

GENITOURINARY	Yes	No
Frequent urination	☐	☐
Burning or painful urination	☐	☐
Blood in urine	☐	☐
Incontinence or dribbling	☐	☐
Kidney stones	☐	☐
Sexual difficulty	☐	☐

MUSCULOSKELETAL			Right	Left
Arm Pain	☐	☐	☐	☐
Leg Pain	☐	☐	☐	☐
Arm Weakness	☐	☐	☐	☐
Leg Weakness	☐	☐	☐	☐
Neck Pain	☐	☐	☐	☐
Upper Back Pain	☐	☐	☐	☐
Low Back Pain	☐	☐	☐	☐

Do you have numbness anywhere? ☐ Yes ☐ No Describe where:

FAMILY MEDICAL HISTORY

	Age	Diseases	If deceased, cause of death
Father	____	_____	_____
		_____	_____
Mother	____	_____	_____
		_____	_____