Name: ____________________________________Age:________Weight:___________Height:____________

Reason for Visit:____

SURGERIES

Surgery	Date	Surgery	Date

Have you had any problems with general anesthesia? Yes No **Please explain:** ________________________

RESPIRATORY:

Have you had any breathing problems? Yes____No_____

	Yes	No
Wheezing………………		
Shortness of breath…………		
Productive or bloody cough		
Asthma……………………..		
Emphysema/COPD………...		
Bronchitis………………….		
Pneumonia………………….		
Pulmonary Embolism………		

CARDIAC:

Have you had any heart problems? Yes____No_____

	Yes	No
Chest pain…………		
Palpitations/heart racing.		
Congestive heart failure.		
Heart attack……………		
Elevated blood pressure.		
High cholesterol……….		
Atrial Fibrillation..…….		
Pacemaker…………….		
Heart valve……..…….		
Rheumatic Fever…..….		
Diabetes………………		

MEDICATIONS

List all medicines, steroids, inhalers, supplements or drugs (prescription or over-the-counter) you are taking now:

Medication	**Dose**	**Frequency**	**Medication**	**Dose**	**Frequency**

ALLERGIES

ALLERGY	TYPE OF REACTION

SOCIAL HISTORY

Do you smoke or use tobacco? **Yes** **No** If yes, how much per day? ____________________

Have you ever smoked? **Yes** **No** Date Quit ________________________________

Do you drink alcohol? **Yes** **No** If yes, how often? _____________________________

Do you use illicit drugs? **Yes** **No**

Are you on a special diet? **Yes** **No** If yes, describe? ____________________________

What is/was your occupation? ____

Reviewed by DR.________________________________Date:_________________________

FAMILY MEDICAL HISTORY

Please indicate if any family member has had any of the following:

	Yes	No	Relationship
Cancer			
Blood pressure problems			
Heart problems/chest pain			
Stroke/TIA			
elevated cholesterol			

	Yes	No	Relationship
Bleeding problems			
Diabetes			
Blood clots			
Varicose veins			
Reaction to anesthesia			

Are you taking any of the following herbal/dietary medications?

	Yes	No
Echinacea (asthma/liver problems)		
Valerian (Excess sedation)		
Ephedra (Heart instability)		
Ginseng (Bleeding, low blood sugar)		
Kava Kava (Excess sedation)		
Garlic (bleeding)		
St. John's Wort (Drug metabolism)		
Metabolife (or diet drugs)		

Other (Please specify):____

Are you taking any over the counter medicines? Yes____ No_____

If yes, please list:____

Are you on dialysis? Yes______ No______

If yes, what is your schedule?

SUN **MON** **TUE** **WED** **THURS** **FRI** **SAT**

HOW WERE YOU REFERRED TO US?

_____ primary care physician ________ specialist _________ friend

_______ ask-a-nurse _______ our patient ________ yellow pages

______ insurance plan list _______ internet _______ other

REVIEWED:

DOCTOR **DATE**

____ ________________

____ ________________

____ ________________

____ ________________

Medical History

Please mark if you have been diagnosed with and/or you are currently having any of the following symptoms:

Neurologic/HEENT:	**Yes**	**No**
Numbness/tingling		
Loss of strength		
Headaches		
Seizures/epilepsy		
Multiple sclerosis		
Ear problems		
Eye problems		
Nose/sinus problems		
Throat problems		
Stroke (CVA/TIA)		

Digestive:	**Yes**	**No**
Abdominal Pain		
Nausea		
Constipation or diarrhea		
Hepatitis		
Colitis		
Diverticulitis		
Hiatal hernia/reflux		
Irritable bowel syndrome		
Ulcers		
Pancreatitis		
Rectal bleeding/pain		
Change in bowel habits		

ENDOCRINE:	**YES**	**NO**
Tired/sluggish		
Excessive thirst		
Diabetes		
Thyroid problems		

GENITOURINARY/GYN:	**YES**	**NO**
Kidney problems/stones		
Bladder infections		
Kidney failure		
Prostate infections		
Uterine problems		

Blood/Immune system:	**Yes**	**No**
Swollen glands		
Anemia		
Cirrhosis		
DVT/phlebitis/clots		
Jaundice		

Psychological/Emotional:	**Yes**	**No**
Nervousness		
Anxiety		
Depression		
Other________________		

Musculoskeletal/Skin:	**Yes**	**No**
Back, neck problems		
Joint pain		
Rash/skin breakdown		
Arthritis		
Fractures		
Osteoporosis		

Communicable Disease:	**Yes**	**No**
AIDS/HIV		
Hepatitis A/B/C		
STD		
Tuberculosis		

Cancer:

Have you ever been diagnosed with cancer? **Yes** **No**

Type: ______________________________________

Treatment: __________________________________

Constitutional:	**Yes**	**No**
Fever		
Chills		
Weight loss		
Night Sweats		