

Name: _____

Date: _____

Why are you here to see the doctor? _____

What drugs are you **allergic** to? _____

Please list **medications** you take – including aspirin and eye or eardrops.

MEDICATION NAME	STRENGTH (MG)	TIMES PER DAY	MEDICATION NAME	STRENGTH (MG)	TIMES PER DAY
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

Please list any **surgeries** you have had and their dates, if known.

Have you ever had difficulty with **anesthesia**? ___ Yes ___ No

What have you been **hospitalized** for besides surgery? _____

Please **circle** any **medical problems** that you have had:

Cancer– of what part of the body _____

- | | | | | |
|------------------|-------------------------|---------------|-------------------------------|------------------|
| Diabetes | High blood pressure | Gout | Thyroid disease | Arthritis |
| Heart trouble | Angina | Heart attack | Mitral valve prolapse | Arrhythmia |
| Lung trouble | Asthma | Emphysema | TB Pneumonia | Glaucoma |
| Ulcer | Colitis | Liver Disease | Bleeding disorder | Leukemia |
| Seizure disorder | Stroke | Back trouble | Blindness High cholesterol | AIDS |
| Nervous disorder | Urinary tract infection | | Kidney disease | Prostate trouble |

Do you **smoke**? ___ Yes ___ No If yes: ___ Packs per day ___ Years
Did you smoke? ___ Yes ___ No Stopped ___ years ago Smoked ___ packs/day ___ Years
Do you **drink**? ___ Yes ___ No How much? _____

Women only: Is it possible that you are **pregnant** now? ___ Yes ___ No

Anything else you feel is important: _____

OVERALL HEALTH REVIEW

Please **circle** those symptoms that you **frequently** experience.

CENTRAL NERVOUS SYSTEM:

Headaches	Dizziness	Seizures	Unconsciousness
Fainting	Poor memory	Paralysis	Speech problems

EYES:

Blindness	Glaucoma	Cataracts	Double vision
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EARS:

Itching	Draining	Ringing	Hearing loss
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NOSE:

Sneezing	Runny nose	Nosebleeds	Trouble reathing
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MOUTH-THROAT:

Sore throat	Hoarseness	Bad breath	Excessive phlegm
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RESPIRATORY:

Wheezing	Cough	Sinus	Shortness of breath
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CARDIOVASCULAR:

Chest pain	Rapid pulse	Irregular pulse
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GASTROINTESTINAL:

Heartburn	Nausea	Vomiting	Trouble swallowing
Diarrhea	Pain	Bleeding	Food intolerance

MUSCLES & JOINTS:

Joint pain	Weakness	Back trouble	Deformities
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SKIN:

Rash	Growths	Eczema	Psoriasis
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GENITO-URINARY:

Vaginal infections	Frequent urination
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MISCELLANEOUS:

Allergic reaction to stinging insects? _____ Allergies to foods? _____

FAMILY HISTORY

Has anyone in your family been treated for any of the following?

PROBLEM	RELATIONSHIP (mother, father, sister or brother)			
Diabetes	M	F	S	B
Tuberculosis	M	F	S	B
Hay fever	M	F	S	B
Asthma	M	F	S	B
Heart disease	M	F	S	B
High blood pressure	M	F	S	B
Hearing loss	M	F	S	B
Other (please specify)				