Name: ______________________________________ Date: ______________________

Why are you here to see the doctor? ____

____

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

EARS:
Itching Draining Ringing Hearing loss

NOSE:
Sneezing Runny nose Nosebleeds Trouble breathing

MOUTH-THROAT:
Sore throat Hoarseness Bad breath Excessive phlegm

RESPIRATORY:
Wheezing Cough Sinus Shortness of breath

CARDIOVASCULAR:
Chest pain Rapid pulse Irregular pulse

GASTROINTESTINAL:
Heartburn Nausea Vomiting Trouble swallowing
Diarrhea Pain Bleeding Food intolerance

MUSCLES & JOINTS:
Joint pain Weakness Back trouble Deformities

SKIN:
Rash Growths Eczema Psoriasis

GENITO-URINARY:
Vaginal infections Frequent urination

MISCELLANEOUS:
Allergic reaction to stinging insects? ________ Allergies to foods or LATEX? ______________

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

Nervous disorder Urinary tract infection Kidney disease Prostate trouble HIV/AIDS

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?____________________________________

____

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 What & How much? ___________________________

CIRCLE if you have used: Pipe Cigars Chew Used from _______ to ______ (dates used)

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)	

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

____

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

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

Are you allergic to LATEX? ___ Yes ___No

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

Anything else you feel is important:____

____