MEDICAL INFORMATION

PATIENT NAME: _____ **DATE:** _____

REFERRED BY: _____

PRIMARY CARE PHYSICIAN: _____

THE FOLLOWING INFORMATION IS VERY IMPORTANT TO YOUR CARE
PLEASE BE SURE TO ANSWER *EVERY* QUESTION
If not filled out fully and accurately it may result in a longer wait time

CURRENT MEDICATIONS: Please list all prescription, over the counter medications and drops
IF YOU HAVE A MEDICATION LIST PLEASE PROVIDE A COPY

MEDICINE NAME	DOSE	MEDICAL DIAGNOSIS
EXAMPLE: Lipitor	20 MG	High Cholesterol

HISTORY OF SKIN CANCER _____ YES _____NO If yes, type of skin cancer: _____
HISTORY OF OTHER CANCER (S) _____ YES _____NO If yes, type of other cancer: _____
DO YOU HAVE DIABETES? _____ YES _____NO INSULIN DEPENDENT? _____
DO YOU HAVE HIGH BLOOD PRESSURE? _____YES _____ NO
HEART HISTORY (Circle all that apply): High Blood Pressure / Pacemaker / A-Fib / Heart Attack / Stent / Stroke
DO YOU TAKE ASPIRIN? _____ YES _____NO

SURGICAL HISTORY	YEAR

DRUG ALLERGIES:

_____
_____
_____
_____

LATEX ALLERGY: YES/NO

SOCIAL HISTORY

WHAT IS YOUR APPROXIMATE HEIGHT? _____ ft _____ in
WHAT IS YOUR APPROXIMATE WEIGHT? _____ lbs

DO YOU USE TOBACCO PRODUCTS? _____ YES _____ NO Year Started: _____
If no, previously? _____ YES _____ NO Year Quit: _____
DO YOU CONSUME ALCOHOL? _____ YES _____ NO
If yes, How often? _____ Daily _____ weekly _____ monthly
DO YOU USE RECREATIONAL DRUGS? _____ YES _____ NO
DO YOU LIVE ____ ALONE _____ WITH SPOUSE _____ OTHER: _____
DO YOU HAVE A LIVING WILL? _____ YES _____NO

REVIEW OF SYSTEMS: Mark all that apply

Constitutional:
- ☐ Normal
- ☐ Fever
- ☐ Weight loss
- ☐ Other _____

Cardiovascular:
- ☐ Normal
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Irregular Heart beat
- ☐ Other _____

Hematologic/Lymphatic:
- ☐ Normal
- ☐ Anemia
- ☐ Blood Disease
- ☐ Free Bleeder
- ☐ Swollen Lymph Nodes
- ☐ Other _____

Neurologic:
- ☐ Normal
- ☐ Weakness
- ☐ Tingling
- ☐ Numbness
- ☐ Other _____

Eyes:
- ☐ Normal
- ☐ Double Vision
- ☐ Pain
- ☐ Discharge
- ☐ Other _____

Respiratory:
- ☐ Normal
- ☐ Shortness of Breath
- ☐ Cough
- ☐ Asthma
- ☐ Other _____

Musculoskeletal:
- ☐ Normal
- ☐ Weakness
- ☐ Joint Pain
- ☐ Decreased ROM
- ☐ Other _____

Psychiatric:
- ☐ Normal
- ☐ Anxiety
- ☐ Depression
- ☐ Mood Swings
- ☐ Other _____

Ears, Nose, Throat:
- ☐ Normal
- ☐ Pain
- ☐ Discharge
- ☐ Hearing Loss
- ☐ Smell
- ☐ Other _____

Gastrointestinal:
- ☐ Normal
- ☐ Changes in Bowel
- ☐ Diarrhea
- ☐ Constipation
- ☐ Stomach Pain
- ☐ Ulcers
- ☐ Other _____

Integumentary: skin/breast
- ☐ Normal
- ☐ Masses
- ☐ Tumors
- ☐ Pigmented Lesions
- ☐ Rash
- ☐ Other _____

FAMILY HISTORY (other than yourself): ***PLEASE CIRCLE ALL THAT APPLY***

☐ Glaucoma	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
☐ Macular Degeneration	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
☐ Blindness	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
☐ Diabetes	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
☐ Cancer	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
☐ Heart Disease	Parent / Sibling / Maternal Grandparent / Paternal Grandparent
☐ Unknown Family History	

I attest that the above information is true and correct to the best of my knowledge

_____
Signature of Patient or Legal Guardian

_____
Reviewed by (FOR OFFICE USE ONLY)

_____
Printed name of Patient

_____
Updated

_____
Date