Name: _________________________________ Birthdate: ____/____/____ Date: ____/____/ 20___

PATIENT HISTORY

Do you currently have or frequently experience...

. Alcoholism	. Cancer: ___________	. High Blood Pressure	. Tuberculosis
. Anemia	. Diabetes	. HIV/AIDS	. Venereal Disease
. Angina/Heart Attack	. Emphysema	. Kidney Disease	
. Arthritis	. Epilepsy or Seizures	. Liver Problem	. Other: ____________
. Asthma/Hay Fever	. Glaucoma	. Lung Problem	
. Birth Defects	. Headaches	. Mental Illness	. Other: ____________
. Bladder Disease	. Heart Failure	. Stroke	
. Bleeding Disorder	. Hepatitis	. Thyroid Problem	. Other: ____________

Drug Allergies?

Current Medications? (including natural, herbal and homeopathic medications)

Surgeries and Injuries?

If female - pregnant?

FAMILY HISTORY

Has anyone in your family had...

. Alcoholism	. Cancer: ___________	. Kidney Disease	. Other: ____________
. Anemia	. Diabetes	. Liver Problem	
. Angina/Heart Attack	. Emphysema	. Lung Problem	. Other: ____________
. Arthritis	. Epilepsy or Seizures	. Mental Illness	
. Asthma/Hay Fever	. Glaucoma	. Stroke	. Other: ____________
. Birth Defects	. Headaches	. Thyroid Problem	
. Bladder Disease	. Heart Failure	. Tuberculosis	
. Bleeding Disorder	. High Blood Pressure		

SOCIAL HISTORY

Do you...

. Exercise Regularly	. Use Alcohol	. Use Tobacco	. Use Drugs
Type: ____________	Beer/Wine/Liquor	Cigarettes/Cigars/Pipe/	Marijuana/Heroin/
How Often: ________	How Often: ________	Snuff/Chew Tobacco	Cocaine/LSD/Crack

Name: ______________________________ Birthdate: ____/____/____ Date: ____/____/ 20 ____

PATIENT REVIEW OF SYSTEMS			
Do you consider yourself generally: . Healthy . Not Healthy . Other: ______________________			
Do you currently have or frequently experience: *(Please check all that apply)*			
Eyes	. Blurred Vision	. Painful eyes . Other: ____________	. Irritation from light . None
Ears, Nose, Throat, & Mouth	. Itching . Rhinitis (Runny Nose) . Bruxism (Grinding Teeth) . Pressure in Ears	. Nose blocked . Sores in mouth . Difficulty Swallowing . Other: ____________	. Post Nasal Drip . Teeth Hurt . Painful Swallowing . None
Cardiovascular (Heart)	. Palpitations/Fluttering of heart	. Pain in chest . Other: ____________	. Shortness of Breath while exercising . None
Respiratory (Lungs)	. Wheezing	. Shortness of Breath While Sitting . Other: ____________	. Cough . None
Gastrointestinal (Stomach)	. Constipation . Indigestion	. Diarrhea . Other: ____________	. Pain . None
Genitourinary	. Hesitation when urinating	. Urination at night . Other: ____________	. Pain when urinating . None
Musculoskeletal	. Soreness	. Weakness . Other: ____________	. Cramping . None
Integumentary (Skin)	. Itchy Skin . Dry Skin	. Lesions on Skin . Other: ____________	. Bleeding . None
Neurological (Nerves)	. Twitch . Abnormal Movements	. Ringing in Ears . Other: ____________	. Dizziness/Vertigo . None
Psychiatric	. Mood Swings . Depression	. Situational Stress . Other: ____________	. Change . None
Endocrine	. Hot Flashes . Cold	. Hair loss/growth . Other: ____________	. Heat . None
Hematologic/Lymph Nodes	. Bleeding easily	. Night Sweats . Other: ____________	. None
Allergic/Immunologic	. Sneezing	. Eye Irritation . Other: ____________	. Reactions . None