Patient Name ______________________ Today's Date: ______________

Medication Allergies Y___ N ___ Please List: ______________________

Surgical Procedures/Hospital Stays

Dates Reason(s)

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____

____

Occupation: ______________________

For Women Only:

Date of Last PAP: ________ Normal: Y/N

Date of Last Mammogram: ________ Normal: Y/N

Number of Pregnancies: ________

Number of Live Births: ________ Irregular Menses: Y/N

Date of Last Immunizations:

Tetanus Shot: ________

Pneumovax: ________

Shingles Shot: ________

List of CURRENT medications:

____

____

____

Past Medical History

Please circle if you have been diagnosed with any of the following (even if resolved):

Arthritis
Asthma/COPD
Blood Clots
Cancer
Type: ________
Chest Pain/Angina
Dementia

Depression
Diabetes
Headaches
Heart Attack
Heart Disease
Heart Palpitations

Heart Surgery
Hepatitis
High Blood Pressure
High Cholesterol
HIV/AIDS
Kidney Disease

Kidney Stones
Liver Disease
Osteoporosis
Pacemaker
Peripheral Vascular Disease
Seizures

Stomach Ulcers
Stroke/CVA/TIA
Thyroid Disease
Other: ________
____
____

ROS **Current Condition- Please Circle all issues you have at this time:**

Constitutional:	Weight Loss	Fever	Chills	Poor Appetite	Fatigue	Weight Gain	Insomnia	Night Sweats
Eyes:	Blurry Vision	Pain	Discharge	Redness	Decreased Vision	Dry Eyes	Double Vision	Other
Ear/Nose/Throat: Date of last **eye exam**: Date of last **dental exam**:	Sore Throat	Hoarseness	Ear Pain	Hearing Loss	Discharge	Nose Bleeds	Tinnitus	Sinus Problems
Cardiovascular:	Chest Pain	Palpitations	Rapid Heart Rate	Heart Murmur	Poor Circulation	Swelling in Legs/Feet	Previous MI	Stent Bypass
Respiratory:	Shortness of Breath	Chronic Cough	Coughing up Blood	Excess Sputum	Barking Cough	Other		
Gastrointestinal: Date of last **colonoscopy**:	Nausea	Vomiting	Diarrhea	Constipation	Blood in Stool	Frequent Heartburn	Trouble Swallowing	Abdominal Pain
Genitourinary:	Increased Urinary Frequency	Blood in Urine	Incontinence	Painful Urination	Urinary Retention	Frequent UTI's	D/C	Infertility
Skin:	Rash	Hives	Hair Loss	Skin Sores or Ulcers	Itching	Skin Thickening	Nail Changes	Mole Changes
Musculoskeletal	Joint Pain	Muscle Aches	Frequent Leg Cramps	Muscles Weakness	Bone Pain	Joint Swelling	Back Pain	Other
Psychiatric:	Anxiety	Depression	Panic Attacks	Use of Anti-Depressants	Other			
Endocrine:	Goiter	Heat Intolerance	Cold Intolerance	Increased Thirst	Change in Skin Pigmentation	Excess Sweating	Unexplained Weight Gain	Other
Neurological:	Seizures	Tremors	Migraines	Numbness	Dizziness Vertigo	Loss of Balance	Slurred Speech	TIA/Stroke
Hem/Lymphatic	Low Blood Count	Easy Bruising	Swollen Lymph Nodes	Transfusion	Prolonged Bleeding	Blood Clots	Other	
Allergies/Immune	Allergic Reaction	Hay Fever	Frequent Infections	Hepatitis	HIV Positive	Positive TB Skin Test		

Family History	Cancer/Type	High BP	Diabetes	High Cholesterol	Heart Disease	Stroke/TIA	Blood Clots
Mother							
Father							
Siblings							
Grandparents							

______________________ ________ ______________________ ________

Reviewed by Date Patient Signature Date