Name: _____ Date: _____/_____/_____

Date of Birth: _____/_____/_____ Reviewed: _____

Medical History

Past Medical History			*If so, please be more specific*
Stroke	Yes	No	
Obstructive Pulmonary Disease	Yes	No	
Kidney Disease	Yes	No	
Thyroid Disease	Yes	No	**Hyper**thyroidism **Hypo**thyroidism
AIDS/HIV	Yes	No	
Hepatitis	Yes	No	Hepatitis **A** Hepatitis **B** Hepatitis **C**
Rheumatoid Disease	Yes	No	
Gout	Yes	No	
Diabetes	Yes	No	Other: _____
DVT/Blood Clot	Yes	No	_____
Heart Disease	Yes	No	_____
High Blood Pressure	Yes	No	

Social History

Do you use tobacco? Yes No Former

Indicate cigarettes, cigar, pipe, chewing tobacco

Do you use alcohol? Yes No

Do you use caffine? Yes No

Family History

	Mother		Father	
Bleeding Disorder	Yes	No	Yes	No
Heart Disease	Yes	No	Yes	No
Stroke	Yes	No	Yes	No
Cancer	Yes	No	Yes	No
Diabetes	Yes	No	Yes	No

Past Surgical History

Surgery	*Year*

Review of Systems

Do you have any of these symptoms? Please circle either Yes or No for each condition.

Constitiutional			**HEENT**			**Respiratory**		
Fever	Yes	No	Headache	Yes	No	Cough	Yes	No
Fatigue	Yes	No	Vision loss	Yes	No	Shortness of breath	Yes	No
Night Sweats	Yes	No	**Gastrointestinal**			**Genitourinary**		
Cardiovascular			Constipation	Yes	No	Unable to urinate	Yes	No
Chest pain	Yes	No	Diarrhea	Yes	No	Pain on urinating	Yes	No
Cyanosis	Yes	No	Persistent vomiting	Yes	No			
Irregular heartbeat	Yes	No						
Metabolic/Endocrine			**Neurological**			**Psychiatric**		
Cold Intolerant	Yes	No	Difficulty walking	Yes	No	Depression	Yes	No
Heat Intolerant	Yes	No	Dizziness	Yes	No	Anxiety	Yes	No
Integumentary			**Hematolgic**			**Immunological**		
Rash	Yes	No	Bleeding problems	Yes	No	Food allergies	Yes	No
						Environmental allergie	Yes	No

Other: _____

_____

_____

Patient Name: _____ Date: _____/_____/_____

Please take a few moments to complete the following medication lists:

Medications ☐ No active medications

	Name of Medication	Strength of Medication	Directions (SIG)	Start Date
1				
2				
3				
4				
5				
6				
7				
8				

Other: _____

_____

_____

_____

Allergies: _____

Primary Care Giver: _____

Name of Pharmacy: _____ Phone: _____

Location: _____