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Patient Name _____

Date of Birth _____

Date of Service _____

Main Complaint _____

Referring/Primary MD _____

Pharmacy Name/# _____

Medication Allergies or Reactions _____

Other Illnesses you now have (if any)		List any Medications you are now taking	
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Your Present Weight _____ Height _____

Do any diseases "Run in the family"? Please explain: _____

Have you recently had? (please circle no or yes):

Fever.....	no	yes	Chest pain.....	no	yes	Stroke.....	no	yes
Weight Gain.....	no	yes	Palpitations.....	no	yes	Black out spells.....	no	yes
Weight Loss.....	no	yes	Wheezing.....	no	yes	Depression.....	no	yes
Night Sweats.....	no	yes	Problems Swallowing....	no	yes	Anxiety.....	no	yes
Vision trouble.....	no	yes	Constipation.....	no	yes	Thyroid problems.....	no	yes
Hearing loss.....	no	yes	Diarrhea.....	no	yes	Diabetes.....	no	yes
Ringing in ears.....	no	yes	Nausea/vomiting.....	no	yes	Anemia (low blood)..	no	yes
Nosebleeds.....	no	yes	Female Trouble.....	no	yes	Excessive bleeding....	no	yes
Dizziness.....	no	yes	Frequent urination....	no	yes	Blood Thinner.....	no	yes
Hoarseness.....	no	yes	Burning with urination...	no	yes	Blood Transfusion.....	no	yes
Allergies.....	no	yes	Lumps in breasts.....	no	yes	Cancer.....	no	yes
Sinus problems.....	no	yes	Itching/Rashes.....	no	yes	Muscle/Joint pain.....	no	yes
Food Allergies.....	no	yes	Contact allergies.....	no	yes	Arthritis	no	yes
Shortness of Breath....	no	yes	Seizures.....	no	yes	Alcohol use.....	no	yes
Cough.....	no	yes	Frequent Headache...	no	yes	Tobacco use.....	no	yes

List any operations you have had:

Operation	Surgeon/Date	Operation	Surgeon/Date
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____