Printed Name________________________________ DOB______/_______/_________________

What brings you to our clinic today?

____

____

What medications are you currently taking, (please include over-the-counter medications)?

____

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____

____

What medical problems do you see a physician on a regular basis for?

____

____

____

Do you have any allergies to any medications?

____

What surgeries have you had in the past?

____

____

Please list your family's medial history?

____

____

Do you smoke, or have you ever smoked? ____

How much? ____

How tall are you? ____

How much do you weigh? ____

Printed Name__________________________________ DOB______/_______/__________________

Please check any of the symptoms you are currently experiencing:

General-Fever__________ Chills __________ Fatigue __________ Change in Appetite ___________

Cardiovascular-Chest Pain___________ Shortness of Breath _______ Difficulty Lying Flat_______

Hematology-Easy Bruising_______ Easy Bleeding____________ Swollen Glands_______________

Psychiatric-Anxiety___________ Depressed Mood _____________ Delusions __________________

Genitourinary-Blood in Urine_____ Difficulty Urinating_______ Frequently Urinating __________

Gastrointestinal-Abdominal Pain_____ Vomiting_______ Diarrhea_________ Constipation_____

Endocrine-Increased Thirst______ Heat or Cold Intolerance_________ Difficulty Sleeping_______

Neurological-Slurred Speech_____ Loss of Strength______ Visual Changes that Come and Go___

Musculoskeletal-Joint Pain__________ Knee Pain_______________ Sciatica____________________

Skin-Hives___________ Ulcers___________ Rash___________ Eczema_________________________

Peripheral Vascular-Wounds on Legs or Feet_____ Cramping Pain in Legs When Walking_____

Cold Hands or Feet______