

Patient Personal History

Name: _____ / _____ / _____
Last First Middle (Or Maiden)

_____ / _____ / _____
Date Date of Birth SS#

Briefly state the reason for this doctor visit: _____

Please list all drug allergies: _____

Past Medical History - if your past medical history includes any of the following, please check.

- | | |
|--|---|
| <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Bleeding tendency or blood disease |
| <input type="checkbox"/> High blood pressure or hypertension | <input type="checkbox"/> Heart disease |
| <input type="checkbox"/> Stroke or Paralysis | <input type="checkbox"/> Arthritis, joint problems, or gout |
| <input type="checkbox"/> Kidney or Bladder Infection | <input type="checkbox"/> Lung or breathing problems |
| <input type="checkbox"/> Tuberculosis or positive skin test | <input type="checkbox"/> Liver disease, Jaundice or Hepatitis |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Gallbladder disease |
| <input type="checkbox"/> Cancer — treated with <input type="checkbox"/> radiation <input type="checkbox"/> chemo | <input type="checkbox"/> Thyroid Trouble |

If you have, or have had, any illness or disease not included above, please list here.

Review of Systems: Please place a check mark before each of the following that apply to you.

- | | |
|--|--|
| <input type="checkbox"/> abnormal shortness of breath with exercise or activity; spells of uncomfortable breathing or asthma | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> 5 or more pounds lost or gained in past 6 months | <input type="checkbox"/> abdominal or back pain |
| <input type="checkbox"/> fluid retention and/or ankle swelling | <input type="checkbox"/> unusual fatigue and/or lack of energy |
| <input type="checkbox"/> sleep propped up in bed | <input type="checkbox"/> frequent pain in legs with <input type="checkbox"/> rest <input type="checkbox"/> walking |
| <input type="checkbox"/> light-headedness, dizziness, vertigo, fainting spells | <input type="checkbox"/> coughing up blood or mucus |
| <input type="checkbox"/> palpitations (thumping or racing heart) | <input type="checkbox"/> insomnia or trouble sleeping |
| <input type="checkbox"/> heartburn, indigestion, gas, bloating, nausea or vomiting | <input type="checkbox"/> nosebleeds or other bleeding problems |
| <input type="checkbox"/> periods of depression and/or anxiety | <input type="checkbox"/> excessive or unexplained thirst |
| <input type="checkbox"/> dental problems | |
| <input type="checkbox"/> problems with sexual function | |

Indicate any symptoms you may be experiencing that are not listed above.

Please list all physicians you are currently seeing:

To the best of my knowledge, the information contained above is accurate and complete.

Patient's Signature

Date

Reviewing Physician

Date