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PATIENT'S NAME: _____ DATE OF VISIT: ____/____/____
DATE OF BIRTH: ____/____/____ OCCUPATION _____

REASON FOR VISIT: _____

CURRENT MEDICINES/DOSES: 1. _____ ALLERGIES TO MEDICINES:
2. _____ 5. _____ 1. _____
3. _____ 6. _____ 2. _____
4. _____ 7. _____

PLEASE LIST ALL PRIOR MAJOR ILLNESSES/SURGERIES (with years)

Illnesses/Injuries 1. _____ 2. _____ 3. _____
Hospitalizations 1. _____ 2. _____ 3. _____
Operations 1. _____ 2. _____ 3. _____

FAMILY HISTORY (please check) Heart Disease Diabetes Cancer Other _____

Which family member? _____

Do you drink soda/coffee/tea? No, never No, but I used to Yes ~ Cups/Drinks per day? _____
Do you drink alcohol? No, never No, but I used to Yes ~ How many drinks? ____/day or wk?
Do you smoke? No, never No, but I used to Yes ~ Packs per day? _____x_____ years
Do you use illicit drugs? No, never No, but I used to Yes ~ Which? _____

HAVE YOU EXPERIENCED ANY OF THE FOLLOWING? (circle Y or N)

CONSTITUTIONAL		CARDIOVASCULAR		GENITOURINARY	
weight gain/loss(>15lbs)	Y N	heart attack	Y N	frequent urination	Y N
constant night sweats	Y N	high blood pressure	Y N	prostate problems	n/a Y N
		heart murmur	Y N		
EYES		GASTROINTESTINAL		SKIN	
double vision	Y N	diarrhea	Y N	past skin cancer	Y N
glaucoma	Y N	heartburn	Y N	past radiation therapy	Y N
EAR/NOSE/THROAT		ENDOCRINE		MUSCULOSKELETAL	
hearing loss	Y N	diabetes	Y N	arthritis	Y N
ear pain	Y N	thyroid disease	Y N	back pain	Y N
ringing in ears	Y N	autoimmune disease	Y N	RESPIRATORY	
balance problems	Y N	NEUROLOGIC		asthma/emphysema	Y N
hearing aid	Y N	headaches	Y N	chronic cough	Y N
difficulty breathing	Y N	seizures	Y N	Tuberculosis	Y N
nosebleeds	Y N	stroke	Y N	PSYCHIATRIC	
nasal drainage	Y N	HEMATOLOGY		anxiety	Y N
sinus problems	Y N	bruise easily	Y N	depression	Y N
snoring	Y N	anemia	Y N	sleep problems	Y N
voice changes	Y N	cancer	Y N		

OTHER _____

If YES to any of the above, please explain: _____

Reviewed by: _____ M.D.