PATIENT NAME ____

PREFERRED LANGUAGE: ______________________ **REFERRING DOCTOR:** ___________________________

Race: White Black Asian Indian/Alaskan Pac isle Other **Ethnicity:** Hispanic Non-Hispanic

Height _________ **Weight** _________ **Most recent Blood Pressure** __________________

ARE YOU CURRENTLY DIAGNOSED WITH OR BEING TREATED FOR: *(please circle all that apply*)

Hypertension Diabetes Cholesterol Cancer Hypothyroidism Arrhythmia
Congestive Heart Failure Asthma Pregnancy HIV/AIDS Kidney Failure Sleep Apnea
Other: ______________________________

HAVE YOU BEEN TREATED FOR: (*please circle all that apply*)

Blindness	Deafness/Hard of Hearing	Tension headache	Migraine
Epilepsy/Seizures	Paraplegia/Quadriplegia		
Angina	Mitral Valve Prolapse	Heart Attack	
Stroke	Atrial Fibrillation	Rheumatic fever	
Poor Blood Clotting	Anemia	Sickle Cell Anemia	
COPD/Emphysema	Tuberculosis	Pneumonia	
Arthritis	Fibromyalgia	Lupus	
Colitis	Colon Polyp	Cirrhosis of Liver	Diverticulitis Of Colon
Gallstones	Hepatitis	Stomach Ulcers	Pancreatitis
Thyroid disorder			
Urinary Incontinence	Prostate Disease		
Drug addiction	Alcoholism		

Other: _______________________________

CANCER: Skin Brain Mouth Throat Lung Breast Stomach Colon Bladder
Kidney Ovary Uterine Bone Muscle Melanoma Other Cancers:

For Children history of:
Pregnancy difficulty Premature birth Developmental delay Speech delay
Hyperactivity Bed wetting Ear infections Snoring Imbalance Environmental allergies
Other:

Please Circle all of the Surgeries you have had:

Eye:	Glaucoma	Cataract				
Ear, Nose:	Septoplasty	Rhinoplasty	Sinus	Tonsillectomy	UPPP	Cleft palate
Neck:	Larynx	Thyroid	Carotids			
Orthopedic:	Cervical spine	Spine other	Joint repair	Joint replacement		
Heart:	Valve	Stent	Bypass			
Lung:	Lobe					
Abdomen:	Liver	Spleen	Stomach	Kidney	Bladder	Gall bladder
	Colon	Ovarian	Hysterectomy		Prostate	
Skin:	Cancer					
Other:						

Please Circle all of the symptoms listed below you currently have:

- **General**

Fatigue Fever Hair loss Excessive hair growth
Night sweat Shakiness Sweating Weight loss Weight problem
Other:

- **Skin**

Itching Rash Sores Skin Thickening Nail changes New lesions/moles
Other:

- **Eye**

Blurry Vision Eye Pain Discharge Dry Eyes Decreased Vision
Other:

- **Ear, Nose & Throat**

Sore Throat Ear Ringing Hearing difficulties Nose Bleeds
Runny nose/congestion Sinus infections Hoarseness
Other:

- **Respiratory/Lung**

Cough Coughing blood Shortness of breath Snoring Wheezing
Other:

- **Cardiovascular/Heart**

Chest pain Ankle swelling Lightheaded spells Irregular heart beat
Other:

- **Gastrointestinal**

Indigestion/Heartburn Abdominal pain Nausea Vomiting
Blood in stool Constipation Diarrhea Difficulty swallowing
Other:

- **Urinary system**

Burning on urination Blood in urine Urinary hesitancy
Other:

- **Gynecological**

Irregular periods Menopausal concerns Hot flashes Infertility
Other:

- **Musculoskeletal**

Back pain Joint pain/stiffness Muscle weakness Muscle Pains
Other:

- **Mental Health**

Anxiety Depression Difficulty concentrating Insomnia
Alcohol/Drug Abuse
Other:

- **Neurological**

Memory loss Dizziness Loss of sensation Tremor Headaches/severe
Other:

- **Endocrine**

Excess Thirst Frequent Urination Intolerance to heat/cold Goiter
Other:

- **Hem/Lymph**

Easy Bruising Blood Clots Swollen Lymph Glands
Other:

- **Allergy Immune**

Allergies/Hay Fever Hives
Other:

Family History:

Hypertension:	father	mother	sibling	grandmother	grandfather
Heart disease:	father	mother	sibling	grandmother	grandfather
Stroke:	father	mother	sibling	grandmother	grandfather
Diabetes:	father	mother	sibling	grandmother	grandfather
COPD:	father	mother	sibling	grandmother	grandfather
Thyroid Disease:	father	mother	sibling	grandmother	grandfather
Head /Neck cancer:	father	mother	sibling	grandmother	grandfather
Other cancer:	father	mother	sibling	grandmother	grandfather
Hearing loss:	father	mother	sibling	grandmother	grandfather
Dizziness:	father	mother	sibling	grandmother	grandfather

Other:

Social History:

Marital Status: Single Married Divorced Widowed

Employment: Full time Part time Unemployed Homemaker Retired Student

Exercise: Regularly Occasional Never

Alcohol Drinks/wk: Never 1-3 4-7 8+

Illicit drugs: Never Former Current

Depression: Over the past 2 weeks feeling down, depressed, or hopeless OR little interest or pleasure in doing things? Yes No

Smoking: Daily Frequent Former Never Decline to state

MEDICAL ALLERGIES: (circle all that apply)

Adhesive Tape Aspirin Clindamycin Ibuprofen Iodine Latex Neomycin Penicillin Polymyxin

Sulfa Vancomycin Protostat Albuterol Tylenol Ampicillin Erythromycin Hycodan Oxycodone Oxycotin

Lopid Toprol Darvocet Percodan Percocet Levaquin Demerol Morphine Vicodin Versed Tramadol

Other: (please list)

Please list all the medications (prescription AND over the counter) you are currently taking:

- **YOUR PHARMACY:**

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