Today's date: ____________________ Primary doctor: ___________________________________

Last name: ______________________________ First name: ________________ Age: _____ Date of birth: __________

Occupation: ____ Gender: ☐ Male ☐ Female

Chief Complaint: What brings you in to see the doctor?

____

____

History of Present Illness: Please tell us more about your problem (onset, duration, severity, side affected, treatments tried, things that make it better, things that make it worse, etc.)

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Review of Systems: Do you have any of the following symptoms? Please check all that apply.

Head:	**Eyes:**	**Mouth:**	**Ears:**
☐ Headache	☐ Blurry vision	☐ Tooth pain	☐ Hearing loss (L / R)
☐ Facial pressure	☐ Double vision	☐ Difficulty swallowing	☐ Dizziness
☐ Facial pain	☐ Blindness (L / R)	☐ Mouth Pain	☐ Ringing (L / R)
☐ Facial droop	☐ Itchy eyes	☐ Snoring	☐ Drainage (L /R)
☐ Facial numbness	☐ Watery eyes	☐ Loss of taste	☐ Pain (L / R)
			☐ Itching (L / R)
Nose:	**Neck:**	**General:**	
☐ Runny	☐ Masses	☐ Fatigue	☐ Heartburn
☐ Dry	☐ Pain	☐ Weight loss	☐ Nausea
☐ Bleeding (L / R)	☐ Trouble breathing	☐ Fever	☐ Vomiting
☐ Loss of smell	☐ Hoarseness	☐ Chest pain	☐ Bloody/tarry stools
☐ Stuffy (L / R)	☐ Cough	☐ Shortness of breath	☐ Frequent urination
☐ Urgency	☐ Itchy skin	☐ Nervousness	☐ Easy bruising
☐ Back pain	☐ Skin rash	☐ Trouble sleeping	☐ Excessive thirst
☐ Joint pain	☐ Numbness/tingling	☐ Daytime sleepiness	☐ Heat/cold intolerance
☐ Joint stiffness	☐ Hyperactivity	☐ Easy bleeding	☐ Reaction to environment

☐ Other conditions not listed

____

____

____

Have you had any surgery? Please list with dates:

____

____

____

____

____

Past Medical History:

☐ Glaucoma	☐ Thyroid disease	☐ Renal failure	☐ Cancer
☐ Cataracts	☐ Bleeding disorders	☐ Anxiety	☐ Headache
☐ Blindness (L / R)	☐ HIV	☐ Depression	☐ Other ____________
☐ Stroke	☐ Sleep apnea	☐ ADHD	☐ Other ____________
☐ Brain aneurysm	☐ Asthma	☐ Arthritis	☐ Other ____________
☐ Anemia	☐ Emphysema/COPD	☐ Sjogren's disease	
☐ High blood pressure	☐ Bronchitis	☐ Lupus	
☐ Heart disease	☐ Pneumonia	☐ Myasthenia gravis	
☐ Heart attack	☐ GERD	☐ Multiple sclerosis	
☐ Atrial fibrillation	☐ Stomach ulcers	☐ Diabetes	
☐ High cholesterol	☐ Hepatitis	☐ Fibromyalgia	

Medications: Please list any medications you are currently taking:

Name	Strength/Amount	How often

Allergies: Are you allergic to any medications? ☐ Yes ☐ No

If yes, please list: ____

Family History: Are the any medical problems that run in your family?

Father: ____

Mother: ____

Other: ____

Social History:

Do you use tobacco? ☐ Yes ☐ No If yes, how many cigarettes a day? _____
How many years have you smoked? _____

Do you drink alcohol? ☐ Yes ☐ No If yes, how many drinks per day? _____

Do you use illicit drugs? ☐ Yes ☐ No If yes, what kind? _____

Do you drink caffeine? ☐ Yes ☐ No If yes, how many cups per day? _____

Do you add salt to your foods? ☐ Yes ☐ No

I acknowledge that the information stated above is true and complete to the best of my knowledge.

_________________________ _________________________ ______________

Patient/ Guardian Signature Patient/ Guardian name Date

_________________________ ______________

Reviewing Physician Signature Date