Today's date: _____ Primary/Referring 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.)

_____

_____

_____

_____

_____

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

Head:
- ☐ Headache
- ☐ Facial pressure
- ☐ Facial pain
- ☐ Facial droop
- ☐ Facial numbness

Eyes:
- ☐ Blurry vision
- ☐ Double vision
- ☐ Blindness (L / R)
- ☐ Itchy eyes
- ☐ Watery eyes

Mouth:
- ☐ Tooth pain
- ☐ Difficulty swallowing
- ☐ Mouth Pain
- ☐ Snoring
- ☐ Loss of taste

Ears:
- ☐ Hearing loss (L / R)
- ☐ Dizziness
- ☐ Ringing (L / R)
- ☐ Drainage (L /R)
- ☐ Pain (L / R)
- ☐ Itching (L / R)

Nose:
- ☐ Runny
- ☐ Dry
- ☐ Bleeding (L / R)
- ☐ Loss of smell
- ☐ Stuffy (L / R)

Neck:
- ☐ Masses
- ☐ Pain
- ☐ Trouble breathing
- ☐ Hoarseness
- ☐ Cough

General:
- ☐ Fatigue
- ☐ Weight loss
- ☐ Fever
- ☐ Chest pain
- ☐ Shortness of breath

- ☐ Heartburn
- ☐ Nausea
- ☐ Vomiting
- ☐ Bloody/tarry stools
- ☐ Frequent urination

- ☐ Urgency
- ☐ Back pain
- ☐ Joint pain
- ☐ Joint stiffness

- ☐ Itchy skin
- ☐ Skin rash
- ☐ Numbness/tingling
- ☐ Hyperactivity

- ☐ Nervousness
- ☐ Trouble sleeping
- ☐ Daytime sleepiness
- ☐ Easy bleeding

- ☐ Easy bruising
- ☐ Excessive thirst
- ☐ Heat/cold intolerance
- ☐ 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