

LAST NAME: FIRST NAME: MI: DOB: **Past Medical History:** Please select all conditions that you have had or are currently having: Cardiovascular Yes No Year/Explain Gastrointestinal Yes No Year/Explain Chest Pain П Gallbladder Problem □ Pacemaker П Constipation High Blood Pressure □ Diarrhea П П **Heart Attack** Liver Problems П High Cholesterol Ulcers Nausea/Vomiting Irregular Heartbeat Other: \_\_\_\_\_ **Endocrine** Yes No Year/Explain Thyroid Disease П Genitourinary Yes No Year/Explain Diabetes Kidney Disease П Hair Loss П Kidney Stones Menopausal П П **Burning Urination** Menstrual Problems □ Frequent Urination П (Women only) Date of Last Menstrual Period \_\_\_\_\_ Incontinence Other:\_\_\_\_ Are you pregnant? \_ П **Psychiatric** No Year/Explain Yes Year/Explain Hematologic/Lymphatic Yes No Depression Hepatitis Anxiety Blood Clots П **Unusual Stress** П Cancers Loss of Concentration ☐ т Respiratory Yes No Year/Explain Neurological Yes No Year/Explain Asthma Strokes Emphysema П Seizures  $\Delta$ Shortness of Breath  $\square$ П Head Injury **Tuberculosis** П П Numbness П COPD П Parkinson's Disease □  $\Box$ Cold/Flu Carpal Tunnel П Spinning Balance Ears/Nose/Throat Year/Explain Yes No Chronic Headaches Dizziness П **Hearing Loss** Musculoskeletal Year/Explain Yes No Sinus Infections Gout П Difficulty Swallowing П **Arthritis** Jaw Pain П П П Joint Stiffness Muscle Weakness Year/Explain **Eves** Yes No Osteoporosis П Glaucoma 

**Broken Bones** 

Joints Replaced

**Double Vision** 

**Blurred Vision** 



## Family Medical History: Please select all conditions that run in your family:

Chest Pain									
Endocrine	Pacemaker High Blood Pressure Heart Attack High Cholesterol Irregular Heartbeat				Gallbladder Problem Constipation Diarrhea Liver Problems Ulcers				
Semitourinary	Other:				Endocrine	Vec	No	Vear/Eynlain	
Frequent Urination	Kidney Stones				Thyroid Disease Diabetes Hair Loss				
Neurological   Neur	•				•				
No	•					_			O
Hematologic/Lymphatic Yes No Year/Explain Hepatitis   Depression   Depression   Hepatitis   Depression   Depr		_							-
Hematologic/Lymphatic Yes No Year/Explain Hepatitis   Depression   Dep	Other:				Are y	you pre	egnant	?	
Blood Clots				Year/Explain	-		_	Year/Explain	S
Cancers	•	_	_		Anxiety				
Respiratory Yes No Year/Explain Asthma		_			Unusual Stress				$\top$
Asthma	Cancers	_ 凵	Ш		Loss of Concentration	n 🗌			_
Asthma	Pagniratory	Voc	No	Vear/Eynlain					
Shortness of Breath	Asthma				Strokes			Year/Explain	>
Tuberculosis  COPD COld/Flu Parkinson's Disease Parkinson's Disease Carpal Tunnel Carpal Tunnel Spinning Balance Chronic Headaches Hearing Loss Hearing Loss Sinus Infections Difficulty Swallowing Jaw Pain  Eyes Glaucoma  Numbness Parkinson's Disease Chronic Headaches Spinning Balance Chronic Headaches Arthritis Joint Stiffness Musculoskeletal Arthritis Joint Stiffness Muscle Weakness Osteoporosis  Osteoporosis	Shortness of Breath								
COPD Cold/Flu Parkinson's Disease Carpal Tunnel Spinning Balance Chronic Headaches Hearing Loss Sinus Infections Difficulty Swallowing Jaw Pain  Musculoskeletal Gout Arthritis Joint Stiffness Muscle Weakness Muscle Weakness Osteoporosis  Muscle Weakness Muscle Weakness Osteoporosis	Tuberculosis				• •		=		
Carpal Tunnel	COPD					_	=		
Ears/Nose/Throat  Dizziness  Hearing Loss  Sinus Infections  Difficulty Swallowing  Jaw Pain  Spinning Balance  Chronic Headaches  Spinning Balance  Chronic Headaches  Chronic Headaches  Arthritis  Joint Stiffness  Muscle Weakness  Muscle Weakness  Osteoporosis	Cold/Flu					_			
Dizziness					•	_			2
Hearing Loss Sinus Infections Difficulty Swallowing Jaw Pain  Sinus Infections Difficulty Swallowing Difficult	Ears/Nose/Throat			Year/Explain			_		
Sinus Infections			_		Chronic Headaches	Ш	Ш		4
Difficulty Swallowing	•							Year/Explain	щ
Jaw Pain □ □ Joint Stiffness □ □   Eyes Yes No Year/Explain Muscle Weakness □ □ □   Glaucoma □ □ □ □ □						=			
Eyes Yes No Year/Explain Muscle Weakness	Jaw Pain								
Glaucoma	<b>F</b>	V.		\// <b>=</b>					
		Yes		rear/⊨xpiain					
				<del></del>	•				

Joints Replaced

Blurred Vision



Year:	Year:
Year:	
Year:	Year:
Year:	Year:
Year:	Year:
Allergies: Please select all that you are allergic to:	
□None □Other □Chemical □Environmental □Food □Me	dication
***If applicable, please list what you are allergic to:	
Medications: Please list any medications you are currently taking:	
inedications. I lease list arry medications you are currently taking.	
Social History: Please answer the following questions:	
Social History: Please answer the following questions:  Marital Status: □Single □Married □Widowed □Divorced □Separated □Do	mestic Partnership
Marital Status: □Single □Married □Widowed □Divorced □Separated □Dor	mestic Partnership
Marital Status: □Single □Married □Widowed □Divorced □Separated □Dol Children: □Yes, I have child(ren) □None	mestic Partnership
Marital Status: □Single □Married □Widowed □Divorced □Separated □Dol Children: □Yes, I have child(ren) □None  Pregnant? □Yes □No If yes, what is your due date?	mestic Partnership
Marital Status: □Single □Married □Widowed □Divorced □Separated □Dorochildren: □Yes, I have child(ren) □None  Pregnant? □Yes □No If yes, what is your due date?  Drink Alcohol? □Yes □No Use Tobacco? □Yes □No	mestic Partnership
Marital Status: Single Married Widowed Divorced Separated Dor Children: Yes, I have child(ren) None Pregnant? Yes No If yes, what is your due date? Drink Alcohol? Yes No Use Tobacco? Yes No Uses recreational drugs? Yes No	
Marital Status: Single Married Widowed Divorced Separated Dor Children: Yes, I have child(ren) None  Pregnant? Yes No If yes, what is your due date?  Drink Alcohol? Yes No Use Tobacco? Yes No  Uses recreational drugs? Yes No  Smoking Status: Current every day smoker Current some day smoker Nev	ver Smoker
Marital Status: Single Married Widowed Divorced Separated Dor Children: Yes, I have child(ren) None Pregnant? Yes No If yes, what is your due date? Drink Alcohol? Yes No Use Tobacco? Yes No Uses recreational drugs? Yes No	ver Smoker
Marital Status: Single Married Widowed Divorced Separated Dor Children: Yes, I have child(ren) None  Pregnant? Yes No If yes, what is your due date?  Drink Alcohol? Yes No Use Tobacco? Yes No  Uses recreational drugs? Yes No  Smoking Status: Current every day smoker Current some day smoker Nev	ver Smoker ght tobacco smoker
Marital Status: Single Married Widowed Divorced Separated Dor Children: Yes, I have child(ren) None  Pregnant? Yes No If yes, what is your due date?  Drink Alcohol? Yes No Use Tobacco? Yes No  Uses recreational drugs? Yes No  Smoking Status: Current every day smoker Current some day smoker Nev	ver Smoker ght tobacco smoker 5-7 times a week None/ unable
Marital Status: Single Married Widowed Divorced Separated Dor Children: Yes, I have child(ren) None  Pregnant? Yes No If yes, what is your due date?  Drink Alcohol? Yes No Use Tobacco? Yes No  Uses recreational drugs? Yes No  Smoking Status: Current every day smoker Current some day smoker New  Former smoker: Smoker, status unknown Heavy tobacco smoker Light  Circle which one applies to you: Workout 1-3 times a week 3-5 times a week	ver Smoker ght tobacco smoker 5-7 times a week None/ unable