

Medical Information

Date _____

Referred by _____

Name _____

Family Physician _____

Medical Conditions	(Circle All That Apply)	None
Diabetes	Arthritis	Hepatitis
High Blood Pressure	Thyroid Disorders	Other: _____
Heart Condition	Heart Arrhythmia	_____
Stroke	Cancer	_____
Asthma	Emphysema	_____
Stomach Ulcers	Shingles	_____
Kidney Stones	HIV/AIDS/ARC	_____

Any Family History Of	(Circle All That Apply)
Glaucoma	High Blood Pressure
Blindness	Diabetes
Lazy Eye	Heart Disease
Retinal Detachment	_____

Current Medications	(Please List All)	None
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Smoke: Y/N _____ Quantity _____

Drink Alcohol: Y/N _____ Consumption _____

Occupation: _____

Hospitalizations / Operations	None
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies To Medications	None
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Review of Systems:	No	Yes	If Yes, Please Explain:
Chronic fever, unexpected weight loss/gain, fatigue?.....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ear/nose/throat problems (e.g., hearing loss, sinus problems, sore throat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart problems (e.g., chest pain, irregular heart beat).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Respiratory problems (e.g., shortness of breath, wheezing, coughing).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Gastrointestinal problems (e.g., heartburn, abdominal pain, diarrhea, nausea).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Urinary problems (e.g., pain or discomfort, blood in urine).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin problems (e.g., rashes, ulcers).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Musculoskeletal problems (e.g., muscle aches, joint pain, swollen joints).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Neurologic problems (e.g., numbness, weakness, new headaches, imbalance).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric problems (e.g., depression, new anxiety).....	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hematologic/lymphatic problems (e.g., bleed easily, lymph node swelling).....	<input type="checkbox"/>	<input type="checkbox"/>	_____