NAME_____ **Date**: _____

REASON FOR TODAY'S VISIT **AND** DURATION OF PROBLEM:

_____

_____

LIST ALL CURRENT MEDICATIONS INCLUDING OVER-THE-COUNTER AND SUPPLEMENTS:

_____

_____

_____

PAST MEDICAL HISTORY/ REVIEW OF SYMPTOMS (Circle all that apply to you as the patient)

Breast disease	Angina	Unexplained fever	HIV/AIDS
Cancer:(type_____)	Chest pain	Unexplained weight loss	Anemia
Change in smell	Heart attack	Asthma	Easy Bleeding
Change in taste	Heart murmur	Bronchitis/Pneumonia	Diabetes
Glaucoma	High Blood Pressure	Chronic cough	Hemophilia
Headaches	High cholesterol	Tuberculosis	Arthritis
Head injury	High triglycerides	Wheezing	Joint Pain
Hearing loss	Palpitations	Colitis	Gout
Migraines	Poor Sleep	Difficulty urinating	Herpes
Prostate disease	Seizures	Kidney disease	Lyme
Ringing in ears	Stroke	Liver disease	Fatigue
Skin rashes	Stomach ulcers	Cold/heat intolerance	
Thyroid problems	Heartburn/reflux	Abdominal pain	Other_____
Snoring	Daytime Tiredness		
			None

Are you pregnant?	Y/N	
Do you take Birth Control Pills?	Y/N	
Is your vision presently normal?	Y/N	If no, explain
Do you have any bleeding disorder?	Y/N	If yes, explain:
Are you taking aspirin, ibuprofen or blood thinning products?	Y/N	If yes, explain:
Do you take antibiotics before surgical or dental procedures because of heart problems or other conditions?	Y/N	

PAST SURGICAL HISTORY

List all operations you have had:_____

_____

ALLERGIC HISTORY If allergic to any of these items (**<u>especially antibiotics</u>)** circle and specify.

MEDICINES ANTIBIOTICS FOODS SURGICAL TAPE LATEX NONE

SPECIFY CIRCLED ITEMS:_____

FAMILY HISTORY (Circle conditions in your blood relatives only)

Allergies	Diabetes	High blood pressure	Lung problems
Bleeding problems	Heart problems	Kidney problems	Liver Problems
Cancer(Type_____)		Hearing loss	Other_____

SOCIAL HISTORY

Do you smoke? Yes No If yes, how many packs per day? _____ How many years?

Do you drink alcoholic beverages? Yes No If yes, how many drinks per week? ____

HEIGHT_____ **WEIGHT**_____

PRIMARY CARE PHYSICIAN _____