Patient Name: _____ **DOB**: _____ **Ht.**: _____ **Wt.**: _____

Reason for Visit: _____ **Date Symptoms Began**: _____

PAST MEDICAL HISTORY

	Y	N		Y	N		Y	N		Y	N
Anemia			Depression			Hepatitis			Parkinson's		
Arthritis or DJD			Diabetes			Type:			Seizures		
Asthma			DVT or Blood Clots			Heart Disease			Sleep Apnea		
Bleeding Tendencies			Emphysema			High Blood Pressure			Stroke or TIA		
Cancer			Epilepsy			High Cholesterol			Thyroid Disease		
Type:			GERD / Acid Reflux			HIV			Other:		
Cataracts			Glaucoma			Kidney Disease					
Chronic Infections			Gout			Kidney Stones					
Connective Tissue Dis.			Heart Attack			Multiple Sclerosis					
COPD			Heart Murmur			MRSA					

PAST SURGICAL HISTORY

Surgery/Hospitalization	Date	Surgery/Hospitalization	Date

Notate additional surgeries on back →

SOCIAL HISTORY

Smoker? ❒ Yes ❒ No Packs per Day: _____ Years: _____ Quit: ❒ Yes ❒ No When? _____
Alcohol use? ❒ Yes ❒ No Type(s): _____ Drinks per week: _____
Caffeine? ❒ Yes ❒ No Type(s): _____ How much per day? _____
Recreational drug use? ❒ Yes ❒ No Type(s) & reason: _____ How often? _____

LIST ALLERGIES AND REACTIONS

_____

_____

VACCINATIONS AND TESTING

Date of last pneumococcal vaccination: _____ ❒ N/A Date of last flu vaccination: _____ ❒ N/A
Date of last colonoscopy and/or sigmoidoscopy: _____ ❒ N/A Date of last mammogram? _____ ❒ N/A
Have you EVER had a problem with anesthesia? ❒ Yes ❒ No Explain: _____
Do you require antibiotics prior to dental procedures? ❒ Yes ❒ No

FAMILY HISTORY (Parent, sibling, or child)

	Y	N	FAMILY MEMBER		Y	N	FAMILY MEMBER
Diabetes				Prostate cancer			
Kidney stones				Bladder cancer			
Heart disease				Other:			
High blood pressure				Other:			

Is there any litigation with a MVA or worker's comp involved with this current reason for visit? **NO** **YES**

Have you had imaging done on your brain or spine? **NO** **YES***

*If yes: MRI CT X-RAY MYELOGRAM Location:_____

LUMBAR THORACIC CERVICAL BRAIN When:_____

Patient Name: _____ **DOB**: _____ **Ht.**: _____ **Wt.**: _____

Reason for Visit: _____ **Date Symptoms Began**: _____

REVIEW OF SYSTEMS: **Do you <u>CURRENTLY</u> have any problems related to the following systems?**

GENERAL	**Y**	**N**	**(NEUROLOGICAL CONT.)**	**Y**	**N**	**GASTROINTESTINAL**	**Y**	**N**	**(GENIITOURINARY CONT.)**	**Y**	**N**
Chills			Numbness			Abdominal pain			Urinary urgency		
Difficulty sleeping			Where?			Black / Bloody stool			**MUSCULOSKELETAL**		
Fatigue			Seizures			Constipation			Back pain		
Fever			Severe, frequent headaches			Diarrhea			History of gout		
History of Blood Transfusion			Tingling			Difficulty swallowing			Joint pain		
Night sweats			Where?			Indigestion/heartburn			Joint swelling		
Unintentional weight change			Tremors			**(GASTROINTESTINAL CONT.)**			Muscle weakness		
HEAD			Weakness			Nausea			Neck pain		
Dizziness			Where?			Vomiting			Weakness of arm		
Double vision			**RESPIRATORY**			Vomiting Blood			Weakness of leg		
Ear pain			Coughing up blood			**PSYCHIATRIC**			**HEMATOLOGY**		
Frequent nosebleeds			Chronic cough			Anxiety			Blood clots		
Hoarseness			Shortness of breath			Depression			Swollen glands		
Mouth sores			Snoring			Feeling hopeless			**ENDOCRINE**		
Ringing in ears			Sore throat			Hearing voices			Excessive thirst		
Sinus problems			Wake from sleep w/ wheezing or shortness of breath			**GENIITOURINARY**			Fatigue		
Trouble hearing			Wheezing			Blood in urine			Too hot/cold		
Visual changes (not glasses)			**CARDIOVASCULAR**			Change in sex drive			**SKIN/HAIR**		
NECK			Chest discomfort / tightness			Change in stream			Hair loss		
Persistent sore throat			Episodes of fainting			Flank pain			Major skin problems		
Swollen glands			Irregular heartbeat			Pain with urination			Poor-healing wounds		
NEUROLOGICAL			Leg or ankle swelling			Urinary Frequency > 8x per day			Rash (persistent)		
Difficulty speaking			Lightheaded			Urinary hesitancy			**OTHER**		
Forgetfulness / Confusion			Smothering feeling at night			Urinary incontinence			Have wet / soiled self on way to toilet		
Loss of coordination						Urinary retention			Have fallen in last 3 months		
						UTI					