Client Name: **Patient Name:**

Yes	No	List allergies you have:
1		Allergies (specify):

Yes	No	List medications you take:
		Medications (specify):
		1.
		2.
		3.
		4.

Yes	No	Do you have any of the following?
		ADD
		Alcoholism or Drug Abuse
		Allergies
		Anxiety / Depression
		Asthma
		Cancer (Specify Type)
		Cardiovascular / Heart Disease
		Congenital Heart Defect
		Diabetes
		Diverticulosis of Colon
		Epilepsy or Seizures
		Hepatitis
		Hyperlipidemia
		Hypertension
		Lyme Disease
		Pneumonia
		Premature Birth
		Sickle-Cell Disease
		Sickle-Cell Trait

Are any of the following symptoms being experienced TODAY?

Yes	No	CONSTITUTIONAL
		Change in appetite
		Chills
		Fatigue
		Fever
		Sweats
		Weight loss/gain
Yes	**No**	**EYES AND VISION**
		Blurred or double vision
		Contact lenses
		Eye discharge
		Eye pain
Yes	**No**	**EARS, NOSE, THROAT, TEETH**
		Dizziness
		Ear pain
		Nasal congestion
		Nose discharge
		Sneezing
		Sore throat
Yes	**No**	**CARDIOVASCULAR / HEART**
		Chest pain or pressure
		Fainting
		Irregular heart beat
Yes	**No**	**RESPIRATORY / LUNGS**
		Congestion
		Cough
		Shortness of breath
		Wheezing
Yes	**No**	**GASTROINTESTINAL SYSTEM**
		Abdominal pain
		Diarrhea
		Nausea
		Urinary / Bowel changes
		Vomiting

Yes	No	Do you have any of the following (Cont.)?
		Stroke
		Thyroid Problem
		Ulcer
		Other:

Yes	No	Have you had Surgeries or Operations?
		Surgeries (specify): |

Yes	No	Does your family have any of the following?	
		Alcoholism: □ Mother □ Father	□ Sibling
		Cancer: □ Mother □ Father	□ Sibling
		Depression/Anxiety: ^ Mother □ Father	□ Sibling
		Diabetes: □ Mother □ Father	□ Sibling
		Heart Disease: □ Mother □ Father	□ Sibling
		High Blood Pressure: □ Mother □ Father	□ Sibling
		Strokes: □ Mother □ Father	□ Sibling
		Substance Abuse: □ Mother □ Father	□ Sibling

Yes	No	Do you use alcohol, drugs or smoke?	
		Tobacco Use: How much ? Day.	
		Alcohol Use: How much ? Week.	
		Druq Use: Druq: I	

Yes	No	Are you employed?
		How long Employed? How Long? Months/Years
		Position?

Yes	No	Menstrual History (woman):
		Are you pregnant?
		Last menstrual date?
		Last pap smear date?
		Last Tetanus shot date?
Yes	**No**	**GENITOURINARY**
		Discharge
		Frequent urination
		Nighttime urination
		Painful urination
Yes	**No**	**MUSCULOSKELETAL**
		Joint pain
		Muscle pain
		Swelling
Yes	**No**	**SKIN**
		Bruising
		Rash / Itching
		Redness
		Skin sores
Yes	**No**	**NEUROLOGICAL**
		Headache
		Light headedness
		Numbness
		Poor balance
		Tingling
		Weakness
Yes	**No**	**PSYCHIATRIC**
		Anxiety/Nerves
		Depression
Yes	**No**	**ENDOCRINE SYSTEM**
		Diabetes
		Hyper or hypothyroid
		Heat or cold intolerance
Yes	**No**	**HEMATOLOGIC/BLOOD DISORDERS**
		Frequent infections
		Swollen glands
Yes	**No**	**IMMUNE SYSTEM**
		Hay fever or allergies
		Food allergies

Height Weight Temp BP / Pulse Resp PO%

Internal Use:
Chief Complaint

Signature: **Date:**