Name:
Chart:
Date:

Sex: ❑ M ❑ F Ethnicity: _____

To be completed by the Medical Assistant
Ht: Wt: BMI:

Primary Care Physician: _____ Any allergies to ❑ latex ❑ iodine ❑ shellfish ❑ N/A

Other Physicians: _____

Are you allergic to any medications? ❑ No ❑ Yes If Yes, Please list:

Medication	Reaction

Medication	Reaction

Have you ever had an EKG or Cardiac Testing done? ❑ No ❑ Yes If yes, please answer:

Type: _____ When _____ Where _____

Past Medical History:

	Yes	No
Asthma	❑	❑
COPD	❑	❑
Sleep Apnea	❑	❑
do you use a CPAP	❑	❑
Diabetes	❑	❑
Type I ❑ Type II	❑	
Angina	❑	❑
High Blood Pressure	❑	❑
Heart Disease	❑	❑
type: _____		
Heart Attack	❑	❑
High Cholesterol	❑	❑
Thyroid Disease	❑	❑

	Yes	No
Kidney Stones	❑	❑
Kidney Disease	❑	❑
Cancer	❑	❑
if yes, type: _____		
Osteoporosis	❑	❑
Headaches	❑	❑
Stroke/CVA/TIA	❑	❑
Seizures	❑	❑
HIV/AIDS	❑	❑
Hepatitis	❑	❑
if yes, type: _____		
cured?	❑	❑
Stomach Ulcer	❑	❑
Acid Reflux	❑	❑

	Yes	No
Liver Disease	❑	❑
Arthritis	❑	❑
Rheumatoid Arthritis	❑	❑
Blood Clots	❑	❑
Peripheral Vascular Disease	❑	❑
Tuberculosis	❑	❑
Depression	❑	❑
Congestive Heart Failure	❑	❑
Pacemaker	❑	❑
Defibrillator	❑	❑
Heart Palpitations	❑	❑
Post Traumatic Stress Disorder	❑	❑
History of MRSA	❑	❑

Other Current Medical Issues: _____

Past Surgical History: Please list ALL surgical procedures you have had done for ANY reason.

Surgery	Date

Surgery	Date

Current Medications: Please list ANY medications, vitamins or herbs you are currently taking:

Medication	Dosage	Frequency

Medication	Dosage	Frequency

Name:
Chart:
Date:

ROS: Please check all **CURRENT** positive findings.

CONSTITUTIONAL ❑(-)
- ❑ Fevers
- ❑ Chills
- ❑ Poor Appetite
- ❑ Fatigue
- ❑ Weight gain
- ❑ Insomnia
- ❑ Night sweats

SKIN ❑(-)
- ❑ Hives
- ❑ Hair loss
- ❑ Skin sores or ulcers
- ❑ Itching
- ❑ Skin thickening
- ❑ Nail changes
- ❑ Mole changes

MUSCULOSKELETAL ❑(-)
- ❑ Muscle aches
- ❑ Frequent leg cramps
- ❑ Muscle weakness
- ❑ Bone pain
- ❑ Joint swelling
- ❑ Back pain
- ❑ Joint Instability

NEUROLOGICAL ❑(-)
- ❑ Tremors
- ❑ Migraines
- ❑ Numbness
- ❑ Dizziness/Vertigo
- ❑ Loss of balance
- ❑ Slurred speech
- ❑ Stroke

GASTROINTESTINAL ❑(-)
- ❑ Nausea
- ❑ Vomiting
- ❑ Diarrhea
- ❑ Constipation
- ❑ Blood in the stool
- ❑ Frequent heartburn
- ❑ Trouble swallowing

ENT ❑(-)
- ❑ Hoarseness
- ❑ Ear pain
- ❑ Hearing loss
- ❑ Ear discharge
- ❑ Nose bleeds
- ❑ Tinnitus
- ❑ Sinus Problems

EYES ❑(-)
- ❑ Blurry vision
- ❑ Eye pain
- ❑ Eye discharge
- ❑ Eye redness
- ❑ Decrease in vision
- ❑ Dry eyes
- ❑ Double vision

GENITOURINARY ❑(-)
- ❑ Increased urinary frequency
- ❑ Blood in the urine
- ❑ Incontinence
- ❑ Painful urination
- ❑ Urinary retention
- ❑ Frequent UTI's

RESPIRATORY ❑(-)
- ❑ Shortness of breath
- ❑ Chronic cough
- ❑ Coughing up blood
- ❑ History of Tuberculosis
- ❑ Excess sputum production

PSYCHIATRIC ❑(-)
- ❑ Anxiety
- ❑ Depression
- ❑ Alcohol or drug dependence
- ❑ Suicidal thoughts
- ❑ Panic attacks
- ❑ Use of anti-depressants

ALLERGIC/IMMUN ❑(-)
- ❑ Allergic reactions
- ❑ Hay fever
- ❑ Frequent infections
- ❑ Hepatitis
- ❑ HIV positive
- ❑ Positive tuberculin skin test (PPD)

CARDIOVASCULAR ❑(-)
- ❑ Chest pain
- ❑ Palpitations
- ❑ Rapid heart rate
- ❑ Heart murmur
- ❑ Poor circulation
- ❑ Swelling in the legs or feet

ENDOCRINE ❑(-)
- ❑ Goiter
- ❑ Heat intolerance
- ❑ Cold intolerance
- ❑ Increased thirst
- ❑ Change in skin pigment
- ❑ Excess sweating

HEM/LYMPHATIC ❑(-)
- ❑ Low blood count
- ❑ Easy bruising
- ❑ Swollen lymph nodes
- ❑ Transfusions
- ❑ Prolonged bleeding
- ❑ Blood clots

Conservative Treatment:

Have you had any Physicial , Massage or Chiropractic therapy? ❑ Yes ❑ No

Have you participated in a home exercise program? ❑ Yes ❑ No

Have you taken any anti-inflammatories? This may include over the counter NSAIDs. ❑ Yes ❑ No

Social History:

Marital Status: ❑Single ❑Married ❑Separated ❑Divorced ❑Widowed ❑Other

Non-Smoker (never smoked) ❑ Ex-Smoker ❑ When did you quit? _____

Current Smoker/Chewer ❑ How much per day? _____

Alcohol consumption: No ❑ Yes ❑ Amount: _____

IV or recreational drug/alcohol dependency: No ❑ Yes ❑ In the past ❑

Currently Employed: No ❑ Yes ❑ Occupation: _____

Family History: (Please list any known medical problems)

Father: _____ Mother: _____

Siblings: _____

Your Children: _____

_____ _____

Signature of Patient Date Signature of Reviewing Physician Date

_____ _____

Updated Signature of Patient Date Updated Signature of Reviewing Physician Date

_____ _____

Updated Signature of Patient Date Updated Signature of Reviewing Physician Date