



Patient: \_\_\_\_\_ Date: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Relationship: \_\_\_\_\_ Emergency Contact Telephone: \_\_\_\_\_

Primary Care Physician: \_\_\_\_\_ Specialist: \_\_\_\_\_

Please list any **medications** (either prescription or over the counter, including vitamins, minerals and herbals) you are currently taking: \_\_\_\_\_

Please list any **medical allergies**: \_\_\_\_\_

Are you pregnant or nursing? NO YES Number of weeks: \_\_\_\_\_
Do you drink alcoholic beverages? NO YES
Do you smoke? NO YES Number of years: \_\_\_\_\_ Packs per day: \_\_\_\_\_

EYES: Have you ever been diagnosed with any of the following?

Table with 5 columns: Condition, YOU (NO/YES), Date Diagnosed, Family History (NO/YES), Relationships (NO/YES). Rows include Glaucoma, Cataracts, Retinal Detachment, Lazy Eye, Macular Degeneration, Eye Turn, Dry Eyes, Eye Injury, Eye Surgery, and Other Eye Problems.

REVIEW OF HEALTH SYSTEMS \_ adopted / family history not known

Have you every been diagnosed with Cancer? \_ No \_ Yes, type: \_\_\_\_\_ Treatment: \_\_\_\_\_

ENDOCRINE (GLANDS)

\_ No Problems
\_ Thyroid Dysfunction \_ Hormonal Dysfunction
\_ Insulin Dependent Diabetes - \_\_\_\_\_ year diagnosed
\_ Non-insulin Dependent Diabetes - \_\_\_\_\_ year diagnosed
Last blood sugar measurement: Last HbA1C:

CARDIOVASCULAR

\_ No Problems
\_ High Blood Pressure \_ Stoke \_ Heart Attack
\_ Vascular Disease \_ Chest Pain
\_ Irregular Heartbeat \_ Heart Failure
Palpitations Bypass \_ Other

NEUROLOGICAL

\_ No Problems
\_ Epilepsy \_ Multiple Sclerosis \_ Neuropathy
\_ Numbness \_ Migraines \_ Parkinsons \_ Other

IMMUNE

\_ No Problems
\_ Rheumatoid Arthritis \_ Sjogren's Syndrome
HIV \_ Lupus \_ Fibromyalgia \_ Other

EARS/NOSE/ THROAT

\_ No Problems
\_ Upper Respiratory Infection \_ Sinusitis \_ Vertigo
\_ Chronic colds \_ Dry Mouth \_ Hearing Loss \_ Other \_ Loss of appetite \_ Other

CONSTITUTIONAL

\_ No Problems
\_ Fatigue \_ Weight Loss/Gain \_ Chills/Fever

GASTROINTESTINAL

\_ No Problems
\_ Heartburn \_ Colitis \_ Hepatitis \_ Jaundice \_ Muscular Dystrophy \_ Osteoarthritis
Ulcer \_ Diarrhea \_ Other \_ Joint Aches \_ Muscle Aches \_ Other

MUSCULOSKELETAL

\_ No Problems

RESPIRATORY

\_ No Problems
\_ Bronchitis \_ Emphysema \_ Shortness of Breath
Tuberculosis \_ Asthma \_ Chronic Coughing \_ Other

INTEGUMENTARY (SKIN)

\_ No Problems
\_ Psoriasis \_ Eczema \_ Rashes \_ Acne
Excessive Dryness \_ Hives Rosacea \_ Other

BLOOD/LYMPH

\_ No Problems
\_ Anemia \_ Leukemia \_ Sickle Cell
Blood clotting Hemophilia \_ Other

PSYCHIATRIC (MENTAL)

\_ No Problems
\_ Depression \_ Bipolar \_ Hallucinations
ADD/ADHD \_ Other

