

PATIENT NAME: _____ DOB: _____ DATE: _____

PLEASE INDICATE DETAILED REASON(S) FOR THIS VISIT:

HOW LONG HAVE YOU HAD THESE PROBLEMS? _____

WHAT OTHER DOCTORS HAVE YOU SEEN? _____

WHAT MEDICATIONS DO YOU TAKE? _____

DO YOU HAVE ANY ALLERGIES? _____

DO YOU HAVE ANY IMPAIRMENT (SPEECH, VISUAL, HEARING, ETC?) _____

DO YOU: SMOKE YES / NO
 DRINK YES / NO
 TAKE DRUGS YES / NO

ARE YOU ON A SPECIAL DIET? YES / NO

DO YOU HAVE ANY RELIGIOUS OR CULTURAL RESTRICTIONS THAT THE DOCTOR SHOULD KNOW ABOUT? _____

DO YOU HAVE A "LIVING WILL" OR ADVANCED DIRECTIVES? YES/NO

WHAT LANGUAGE(S) DO YOU SPEAK, READ OR WRITE: _____

WERE YOU REFERRED? YES/ NO BY WHOM: _____

HAVE YOU EVER BEEN SUSPECTED OF HAVING THE FOLLOWING – (PLEASE CIRCLE)

	<u>PATIENT</u>	<u>FAMILY</u>
DIABETES	YES / NO	YES / NO
HYPERTENSION	YES / NO	YES / NO
HEART DISEASE	YES / NO	YES / NO
ARTHRITIS	YES / NO	YES / NO
BLOOD CLOTS	YES / NO	YES / NO
KIDNEY PROBLEMS	YES / NO	YES / NO
STROKE	YES / NO	YES / NO
TUMOR	YES / NO	YES / NO
NEUROLOGICAL PROBLEMS	YES / NO	YES / NO
<u>OTHER</u> _____		YES / NO
_____		YES / NO

PATIENT NAME: _____ DOB: _____ DATE: _____

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS YOU MAY HAVE

HEAD, EARS, EYES, NOSE, THROAT

- HEADACHES
- HEARING LOSS
- RINGING EARS
- VISUAL CHANGES
- SORE THROAT
- NOSE BLEEDS
- NONE OF THE ABOVE

MUSCULAR/SKELETAL

- JOINT PAIN
- LIMITED MOTION
- BACK PAIN
- MUSCLE ACHES & PAINS
- MUSCLE WEAKNESS
- NONE OF THE ABOVE

INTESTINES

- NAUSEA, VOMITING
- DIARRHEA, CONSTIPATION
- ABDOMEN PAIN
- WEIGHT CHANGE
- APPETITE CHANGE
- JAUNDICE
- NONE OF THE ABOVE

URINARY

- URINARY FREQUENCY
- BLOOD IN URINE
- LITTLE OR NO URINE
- STONES
- PUS IN URINE
- INCONTINENCE
- NONE OF THE ABOVE

CARDIAC/RESPIRATORY

- CHEST PAIN
- BLUE LIPS, NAIL BEDS
- DIFFICULTY BREATHING
- COUGH
- SPUTUM
- VARICOSE VEINS
- NONE OF THE ABOVE

SKIN

- RASH
- ITCHING
- SORES
- TEMP. WARM/CLAMMY
- FLUID RETENTION
- NONE OF THE ABOVE

NEUROLOGICAL

- HEADACHES
- SPEECH DIFFICULTY
- EQUILIBRIUM (BALANCE)
- LOSS OF SLEEP

- CONVULSIONS
- TREMORS
- NUMBNESS
- DREAMS/NIGHTMARES
- LOSS OF VISION

- DIZZINESS
- PARALYSIS
- SENSORY LOSS
- ANXIOUSNESS

FAMILY HISTORY

NUMBER OF CHILDREN: _____

MOTHER LIVING DECEASED CAUSE OF DEATH _____

FATHER LIVING DECEASED CAUSE OF DEATH _____

BROTHERS _____ LIVING DECEASED CAUSE OF DEATH _____

SISTERS _____ LIVING DECEASED CAUSE OF DEATH _____

COMMENTS OR ADDITIONAL INFORMATION:
