

Medications: *(please list all medications and supplements that you currently take)*

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies: *(please list all medications that cause allergic reaction)*

_____	_____	_____
_____	_____	_____
_____	_____	_____

Smoking: ___ Yes ___ No If yes, _____ Packs per Day for _____ years

Alcohol ___ Yes ___ No If yes, Number of drinks per week _____

Surgical History: Please list ALL previous surgery and the date on which it was performed:

Surgery _____	Date _____
_____	_____
_____	_____
_____	_____

Personal Medical History & Review of Systems:

Please indicate with an "X" any medical problems that you currently have or have had in the past.

NO MEDICAL PROBLEMS - no prior history of any significant medical problems

Lungs / Pulmonary – breathing disorders

- | | | |
|------------------------------------|---|---|
| <input type="checkbox"/> asthma | <input type="checkbox"/> pulmonary embolism | <input type="checkbox"/> respiratory arrest |
| <input type="checkbox"/> COPD | <input type="checkbox"/> pneumonia | <input type="checkbox"/> sleep apnea |
| <input type="checkbox"/> emphysema | <input type="checkbox"/> tuberculosis | <input type="checkbox"/> other: _____ |

Cardiac / Heart and peripheral vascular disease

- | | | |
|---|---|--|
| <input type="checkbox"/> chest pain / angina | <input type="checkbox"/> high blood pressure | <input type="checkbox"/> irregular heartbeat, arrhythmia |
| <input type="checkbox"/> heart attack | <input type="checkbox"/> heart murmur, valve disorder | <input type="checkbox"/> peripheral vascular disease |
| <input type="checkbox"/> congestive heart failure | <input type="checkbox"/> mitral valve prolapse | <input type="checkbox"/> deep vein thrombosis |
| <input type="checkbox"/> other: _____ | <input type="checkbox"/> bleeding problems | |

Neurologic Disorders

- | | | |
|--|--------------------------------------|---|
| <input type="checkbox"/> stroke or TIA | <input type="checkbox"/> Parkinson's | <input type="checkbox"/> cerebral palsy |
| <input type="checkbox"/> peripheral neuropathy | <input type="checkbox"/> MS | <input type="checkbox"/> polio |
| <input type="checkbox"/> other: _____ | | |

Bone & Joint Disorders

- | | | |
|---|--------------------------------|---|
| <input type="checkbox"/> osteoarthritis | <input type="checkbox"/> gout | <input type="checkbox"/> osteomyelitis |
| <input type="checkbox"/> rheumatoid arthritis | <input type="checkbox"/> lupus | <input type="checkbox"/> ankylosing spondylitis |
| <input type="checkbox"/> other: _____ | | |

Patient Name: _____ Date: _____

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Doctor's Initials _____

Gastrointestinal Disorders

- peptic ulcer or stomach ulcer
- acid reflux, GERD
- GI bleed
- other: _____
- diverticulitis
- irritable bowel
- inflammatory bowel disease
- hepatitis - Type _____
- liver disease

Genitourinary Disorders

- urinary tract infection
- bladder problems
- kidney problems
- kidney stones
- dialysis, kidney failure
- other: _____

Metabolic & Other Disorders

- Diabetes x _____ years
- thyroid problems
- sickle cell disease
- high cholesterol or lipids
- skin disorder _____
- psoriasis
- any skin ulcer
- tooth abscess, gingivitis
- depression
- anxiety
- alcohol or drug dependency
- other: _____

Cancer: any type -- please specify

Other medical problems NOT included above (explain)

Family History:

Please indicate with an "X" any significant family medical history or problems.

- asthma
- COPD or Emphysema
- heart attack, myocardial infarction
- irregular heartbeat, arrhythmia
- MS or Parkinson's
- osteoarthritis
- rheumatoid arthritis
- acid reflux, GERD
- liver disease
- kidney problems
- diabetes
- thyroid problems
- Malignant hyperthermia
- tuberculosis
- other lung : _____
- congestive heart failure
- bleeding problems
- Peripheral neuropathy
- other neuro : _____
- Lupus
- Other bone & joint: _____
- inflammatory bowel disease
- other GI : _____
- sleep apnea
- gout
- hepatitis - Type _____
- dialysis, kidney failure
- high cholesterol or lipids
- any skin ulcer

Cancer: any type -- please specify

Other medical problems NOT included above (explain)

Patient Name: _____

Date: _____

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PATIENT INSURANCE INFORMATION:

Please check any and all insurance coverage you or your spouse has applicable in this case.

- | | | |
|--|---|--|
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Aetna | <input type="checkbox"/> Auto Accident |
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Major Medical | <input type="checkbox"/> Union Plan |
| <input type="checkbox"/> Blue Cross
Blue Shield | <input type="checkbox"/> Worker's
Compensation | <input type="checkbox"/> Other |

Insurance Identification Number: _____

Medicare/Medicaid Identification Number: _____

Major Medical or Auto Insurance (If involved in an accident):

Date of Accident: _____

Insurance Company Name: _____

Adjuster: _____

Address/Phone: _____

Claim #: _____ Policy #: _____ Effective Date: _____

Primary Care Physician:

Name & Address: _____

Phone #: _____

Would you like us to contact the physician listed above with your exam findings and care plan? By marking "Yes", you give this office the permission to send your health information to the physician indicated above. Please mark: Yes NO

LEGAL INFORMATION (If involved in an accident):

Attorney Name & Address: _____

Attorney Phone #: _____

***Person to contact in an emergency (Name and Phone #):**

Patient Name: _____ Date: _____

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Doctor's Initials _____