

Please fill out this form completely. This will help us see you faster.

REASON FOR VISIT: _____

Please list all the medications, including over the counter medications that you are taking or have recently been taking.

| Medication | Dose | Times/day | Date Stopped | Medication | Dose | Times/day | Date Stopped |
|------------|------|-----------|--------------|------------|------|-----------|--------------|
| | | | | | | | |
| | | | | | | | |
| | | | | | | | |

Please list any allergies to food or medication you may have:

Allergy: _____
 Allergy: _____
 Allergy: _____

What Happens _____
 What Happens _____
 What Happens _____

Have you had: A tetanus shot within the last 10 years? YES / NO A flu shot? Yes / NO All childhood immunizations? YES / NO
 List any other immunizations you may have had: _____

Do you have any symptoms currently? YES / NO Please check the symptoms below that apply to you today:

| | | | |
|---|---|---|--|
| General: <input type="checkbox"/> Overall feeling is poor <input type="checkbox"/> Tired <input type="checkbox"/> Fever <input type="checkbox"/> Chills <input type="checkbox"/> Weight changes <input type="checkbox"/> General pain Head: <input type="checkbox"/> Any head-related symptoms? <input type="checkbox"/> Headache <input type="checkbox"/> Face pain <input type="checkbox"/> Sinus pain Eyes: <input type="checkbox"/> R eye problem <input type="checkbox"/> L eye problem <input type="checkbox"/> Vision/eyesight problems <input type="checkbox"/> Discharge from eyes <input type="checkbox"/> Itching <input type="checkbox"/> Sensitive to light <input type="checkbox"/> Red <input type="checkbox"/> Swollen Ears: <input type="checkbox"/> Earache <input type="checkbox"/> Pulling at ears <input type="checkbox"/> Ringing | Nose & Sinus: <input type="checkbox"/> Nose bleeding <input type="checkbox"/> Drainage or discharge Mouth & Throat: <input type="checkbox"/> Sore throat Oral Cavity: <input type="checkbox"/> Teeth symptoms or pain <input type="checkbox"/> Jaw symptoms or pain Neck: <input type="checkbox"/> Neck pain <input type="checkbox"/> Muscle tightness <input type="checkbox"/> Neck stiffness <input type="checkbox"/> Neck muscle spasm <input type="checkbox"/> Neck lumps <input type="checkbox"/> Neck glands swollen Breast: <input type="checkbox"/> R breast symptoms <input type="checkbox"/> L breast symptoms <input type="checkbox"/> Warmth <input type="checkbox"/> Pain in the breasts Cardiac: <input type="checkbox"/> Pain or discomfort in the chest <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart rate too slow <input type="checkbox"/> Heart rate too fast | Lung: <input type="checkbox"/> Congested in chest <input type="checkbox"/> Breathing difficulty <input type="checkbox"/> Shortness of breath at night <input type="checkbox"/> Cough Gastrointestinal: <input type="checkbox"/> Appetite changes <input type="checkbox"/> Heartburn <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Diarrhea <input type="checkbox"/> Constipation <input type="checkbox"/> Other symptoms (please list) _____ Genitourinary: <input type="checkbox"/> Painful urine <input type="checkbox"/> Urine odor <input type="checkbox"/> Discharge <input type="checkbox"/> Blood in the urine <input type="checkbox"/> Loss of control with urine <input type="checkbox"/> Unusual vaginal discharge <input type="checkbox"/> Male genital or urine symptoms Endocrine: <input type="checkbox"/> Increased/Excess Thirst <input type="checkbox"/> Excess sweating | Skin: <input type="checkbox"/> Itching <input type="checkbox"/> Skin lesions or sores <input type="checkbox"/> Skin wound/s <input type="checkbox"/> Redness of the skin Muscle/Bone: <input type="checkbox"/> Soft tissue swelling <input type="checkbox"/> Back symptoms <input type="checkbox"/> Joint pain <input type="checkbox"/> Joint swelling <input type="checkbox"/> Joint stiffness Nerve Symptoms: <input type="checkbox"/> Dizziness <input type="checkbox"/> Spinning sensation or vertigo <input type="checkbox"/> Fainting sensation <input type="checkbox"/> Difficulty moving arms/legs/other body part <input type="checkbox"/> Tingling <input type="checkbox"/> Numbness <input type="checkbox"/> Increased sensitivity to touch Psychological: <input type="checkbox"/> Mood changes <input type="checkbox"/> Sleep disturbances <input type="checkbox"/> Loss of pleasure <input type="checkbox"/> Energy changes Please explain if you checked any above: _____ _____ |
|---|---|---|--|

List ALL your medical conditions (e.g.: Diabetes, Stroke, etc.) AND list any surgeries you may have had (e.g.: appendectomy, brain surgery)

| | | | |
|----|----|-----|-----|
| 1. | 5. | 9. | 13. |
| 2. | 6. | 10. | 14. |
| 3. | 7. | 11. | 15. |
| 4. | 8. | 12. | 16. |

Do you smoke or use tobacco products? YES / NO How much? _____ Have you quit? YES / NO Do you use alcohol? YES / NO
 Do you drink caffeinated products? YES / NO Do you use recreational drugs? YES / NO Children in daycare? YES / NO

FAMILY MEMBERS: Please list any health problems in your family.

| | | |
|-----------|-----------------------|-----------------------|
| Mother: | Good Health? YES / NO | List health problems: |
| Father: | Good Health? YES / NO | List health problems: |
| Siblings: | Good Health? YES / NO | List health problems: |
| Children: | Good Health? YES / NO | List health problems: |

Print Patient's Name: _____ Patient's Date of Birth: _____

Patient Signature/Legal Guardian: _____ Date: _____