

Name: _____

Date: _____

Has anyone in your family developed the following since your last visit?

Cancer		Tuberculosis	
Allergies		Heart disease at an early age	
High Blood Pressure		Gout	
Convulsions or Epilepsy		Mental Disorder	
Rheumatoid Arthritis		Diabetes	
Stroke(s)		Other:	

REVIEW OF SYSTEMS: REVIEW THE LIST BELOW AND CHECK ANY THAT DESCRIBE A PROBLEM YOU ARE CURRENTLY HAVING OR HAVE HAD IN THE PAST 6 MONTHS.

BACK PAIN-HIGH		JAUNDICE (YELLOW SKIN)	
BACK PAIN-LOWER		JOINT PAIN	
BLACK LOOSE STOOLS		JOINT SWELLING	
BLEEDING BETWEEN PERIODS		LAST MAMMOGRAM	
BLOOD IN URINE		LAST MENSTRUAL PERIOD	
BREAST DISCHARGE		LAST PELVIC EXAM	
CHANGE IN GLOVE, SHOE OR HAT SIZE		LEAKAGE OF URINE	
CHANGES IN VOICE		LOSS OF APPETITE	
CHEST PAIN OR TIGHTNESS IN CHEST		LOSS OF HAIR	
CHRONIC FATIGUE OR WEAKNESS		LUMPS ON BREAST	
CHRONIC CONSTIPATION		MOOD SWINGS	
CONTINUOUS FEVER FOR GREATER THAN 5 DAYS		MUSCLE CRAMPS IN EXTREMITIES	
COUGH		CHRONIC NAUSEA	
COUGHING UP BLOOD		NERVOUSNESS	
CRYING SPELLS		NIGHT SWEATS	
DEPRESSION AND ANXIETY		PAIN IN LEGS WHILE WALKING	
CHRONIC DIARRHEA		PAIN ON URINATION	
DIFFICULTY STARTING URINE STREAM		PAINFUL PERIODS	
DIFFICULTY WITH MEMORY		PALPITATIONS	
DISCHARGE FROM PENIS		PASS A STONE IN URINE	
DRY SKIN		PROBLEM WITH THINKING CLEARLY	
EASY BRUISING		SEVERE HEADACHES	
EXCESSIVE BLEEDING AFTER CUTTING SKIN		SHORTNESS OF BREATH AT NIGHT	
EXCESSIVE SWEATING		SHORTNESS OF BREATH WHILE WALKING	
FREQUENT URINATION (PASSING WATER		SKIN PALLOR (PALENESS)	
HAVE BLOOD WITH BOWEL MOVEMENTS		SKIN RASH	
HEART ATTACK		STOMACH PAIN	
HEMORRHOIDS		STOMACH ULCERS	
HIGH BLOOD SUGAR		SWELLING OF LEGS	
HIGH CHOLESTEROL		TROUBLE SWALLOWING	
HIVES		VAGINAL DISCHARGE	
INCREASE IN HAIR GROWTH		VOMIT BLOOD	
INCREASE OF EXCESSIVE SKIN OIL		VOMITING	
INSOMNIA (DIFFICULTY SLEEPING)		WEIGHT GAIN IN PAST YEAR	
IRREGULAR PERIODS		WEIGHT LOSS	
ITCHING OF SKIN		WHEEZING	

Present Illness (Reason for Visit): _____

Have you been hospitalized in the last year? YES _____ NO _____

When? _____ Where? _____

Do you drink alcohol? _____ If so, how much? _____

Do you smoke? _____ If so, How much? _____

CURRENT MEDICATION FLOW SHEET

Patient Name: _____ **Date of Birth:** _____

Allergies: _____ **Today's Date:** _____

Have You Ever Had a Reaction From Anesthesia? YES or NO If yes Explain: _____

Have You Ever Had a Reaction From Latex? YES or NO If yes Explain: _____

LIST MEDICATIONS AND DOSAGE

PLEASE INCLUDE HERBAL AND OTC	Leave Blank for Nurse to Complete These Columns Below						
	↓			↓			↓
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							
11.							
12.							
13.							
14.							
15.							

Do you have a pacemaker? YES _____ NO _____

Do you have a defibrillator? YES _____ NO _____
(If yes to the above, may we make a copy of your card?)

Do you have any artificial Joints? YES _____ NO _____
If so, what and when placed? _____