



**PATIENT NAME** \_\_\_\_\_ **DATE** \_\_\_\_\_

List any **ALLERGIES** you have: \_\_\_\_\_

\_\_\_\_\_

List any **MEDICATIONS** you take: \_\_\_\_\_

\_\_\_\_\_

Year of your last **TETANUS** shot: \_\_\_\_\_

\_\_\_\_\_

List any previous significant **TRAUMA**: \_\_\_\_\_

Indicate any **SURGERIES** you have had:  NONE

- |                                   |                                      |
|-----------------------------------|--------------------------------------|
| <input type="checkbox"/> Appendix | <input type="checkbox"/> Hernia      |
| <input type="checkbox"/> Tonsils  | <input type="checkbox"/> Gallbladder |
| <input type="checkbox"/> Uterus   | <input type="checkbox"/> Tubes Tied  |
| <input type="checkbox"/> Heart    | Other: _____                         |

Do **YOU** have any of the following medical problems:

- |   |  |                                 |
|---|--|---------------------------------|
| <input type="checkbox"/> Diabetes       | <input type="checkbox"/> Arthritis           | <input type="checkbox"/> AIDS   |
| <input type="checkbox"/> Asthma or Lung | <input type="checkbox"/> High Blood Pressure |                                 |
| <input type="checkbox"/> Heart          | <input type="checkbox"/> Cancer              | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Other: _____   |  |                                 |

Do you smoke?  Yes  No

Packs per day \_\_\_\_\_ for \_\_\_\_\_ yrs.

Do you drink alcohol  Yes  No

If yes, how many drinks per week? \_\_\_\_\_

Do you take drugs **NOT** prescribed by a doctor?

- Yes  No

Check any of the following that you have had **RECENTLY**:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Fever/chills                 | <input type="checkbox"/> Vomiting               | <input type="checkbox"/> Dizziness                |
| <input type="checkbox"/> Weight Loss                  | <input type="checkbox"/> Diarrhea               | <input type="checkbox"/> Numbness                 |
| <input type="checkbox"/> Eye pain                     | <input type="checkbox"/> Pain when Urinating    | <input type="checkbox"/> Depression               |
| <input type="checkbox"/> Drainage from eyes           | <input type="checkbox"/> Frequency of urination | <input type="checkbox"/> Hallucinations           |
| <input type="checkbox"/> Ear pain                     | <input type="checkbox"/> Phlegm                 | <input type="checkbox"/> Excessive thirst         |
| <input type="checkbox"/> Very tired                   | <input type="checkbox"/> Difficulty breathing   | <input type="checkbox"/> Heat or cold intolerance |
| <input type="checkbox"/> Weakness                     | <input type="checkbox"/> Constipation           | <input type="checkbox"/> Excessive thirst         |
| <input type="checkbox"/> Recent vision changes        | <input type="checkbox"/> Abdominal pain         | <input type="checkbox"/> Bleed excessively        |
| <input type="checkbox"/> Nasal congestion or bleeding | <input type="checkbox"/> Blood from bowels      | <input type="checkbox"/> Joint pain or swelling   |
| <input type="checkbox"/> Sore throat                  | <input type="checkbox"/> Blood in urine         | <input type="checkbox"/> Bruise easily            |
| <input type="checkbox"/> Chest Pain                   | <input type="checkbox"/> Flank pain             | <input type="checkbox"/> Passing out              |
| <input type="checkbox"/> Heart palpitations           | <input type="checkbox"/> Neck pain              | <input type="checkbox"/> Seizures                 |
| <input type="checkbox"/> Shortness of Breath          | <input type="checkbox"/> Back pain              | <input type="checkbox"/> Anxiety                  |
| <input type="checkbox"/> Ankle swelling               | <input type="checkbox"/> Rash                   | <input type="checkbox"/> Suicidal thoughts        |
| <input type="checkbox"/> Cough                        | <input type="checkbox"/> Itching                | <input type="checkbox"/> Excessive urination      |
| <input type="checkbox"/> Wheezes                      | <input type="checkbox"/> Arm pain               | <input type="checkbox"/> Swollen glands           |
| <input type="checkbox"/> Nausea                       | <input type="checkbox"/> Leg pain               | <input type="checkbox"/> Change in skin color     |
|   | <input type="checkbox"/> Headache               |   |

**Male:**

- Testicle pain  Discharge from penis

**Female:**

- Last menstrual period \_\_\_\_\_  Vaginal discharge
- # of pregnancies \_\_\_\_\_  Miscarriages
- # of live childbirths \_\_\_\_\_  Discharge from breast
- Breast pain  Other: \_\_\_\_\_