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

Please List All Prescriptions, Over the Counter Medications, Vitamins and Herbal Supplements

DRUG NAME	DOSAGE	CONDITION	FREQUENCY

Any Drug Allergies: YES or NO? **Please List:**

List Any Surgeries & Year:

Last Dental Visit:

Do You Smoke?	*(Circle One Answer)*	Never Smoked	Current smoker, daily
		Former Smoker	Current smoker, occasionally

Family History: List illness/disease in your immediate family:

General ****Please Circle All That Apply ****

Allergies Alcoholism	Edema	Hepatitis Herpes	Osteoporosis
Anemia	Emphysema	High or Low Cholesterol	Pace maker
Appendicitis	Epilepsy	HIV/AIDS Influenza	Parkinson's
Arteriosclerosis	Fatigue	Loss of sleep	Pneumonia
Asthma Bronchitis	Fainting Fever	Malaria Mental Illness	Polio
Cancer Chicken pox	Goiter Gout	Miscarriage Multiple sclerosis	Stroke Thyroid disease
Depression	Headaches	Mumps	Tuberculosis
Diabetes Dizziness	Heart burn	Nervousness Tremors	Ulcers
Eczema	Heart disease	Numbness / tingling	Weight loss / gain

Cardiovascular

High blood pressure	Pain over heart	Hardening of the arteries	Rapid or Slow heart beat
Low blood pressure	Palpitation	Poor circulation	Swelling of ankles
Irregular pulse			

Gastrointestinal

Abdominal pain	Constipation Diarrhea	Hernia Hemorrhoids	Painful defecation
Bloated abdomen	Difficulty digesting	Intestinal worms	Pain over stomach
Bloody or tarry stool	Diverticulosis	Jaundice	Poor appetite
Colitis / Crohn's	Excessive hunger	Liver trouble	Vomiting
Colon trouble	Gallbladder trouble	Nausea	Vomiting of blood

Muscle / Joint

Arthritis Rheumatism	Low back pain Neck pain	Chest pain Chronic cough	Spitting up phlegm / blood
Bursitis Foot trouble	Mild back pain	Difficulty breathing Hay Fever	Wheezing
Joint pain: _____	Muscle weakness	Shortness of breath	

Respiratory

Skin

Boils Bruise easily	Rash	Bed-wetting Bladder infection	Prostate Trouble
Dryness Itching	Varicose veins	Blood in urine Pus in urine	Stress Incontinence
Hives or Allergies		Kidney stones Kidney infection	

Genitourinary

Urination

Painful urination	Overnight more than 2x	Colds Deafness Ear ache	Hoarseness Nasal obstruction
Urgency to urinate	Decreased flow/force	Eye Pain Gum Trouble	Ringing of the ears
More that 8x in 24hrs		Tonsillitis Nose bleeds	Sinus Infection Sore Throat

Eye, Ear, Nose & Throat

Women Only	Hot flashes	**Are you Pregnant? Yes or No**	Menstrual flow: *circle*
Congested breasts	Menopause	If yes, how many months? _____	Reg - Irreg.-Pain/Cramps
Lumps in breast	Vaginal discharge	Result of last mammogram: _____	Result of last PAP:_____