Please fill out and bring with you to your first appointment. Thank you!

Reason for this visit: ______________________________

What symptoms intially led to your diagnosis: ______________________________

Pharmacy Name and Number: ______________________________

Current Medications (Include prescriptions, over-the-counter medications, supplements, vitamins and herbs):

Name of Medicine	Strength of Dose (mg)	How often Taken	Reason Taken

Drug Allergies / Reactions: ______________________________

Vaccinations: (Year last vaccinated)

Pneumonia ____________ Hepatitis ____________
Tetanus ____________ Rubella ____________
Influenza ____________ Other ____________

Medical History: ______________________________

HOSPITALIZATIONS		SURGERIES	
Year	Reason	Year	Reason

Do you have a living will or advanced directive? [ ] No [ ] Yes (Please provide a copy)

Patient Name: ______________________________ DOB: ____________

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FAMILY HEALTH HISTORY

Please place an "X" in the relevant boxes, indicate "L" for living and "D" for deceased, include age if known

Condition:	Mother	Father	Sibling	Maternal: GM or GF	Paternal: GM or GF
Cancer (specify type)					
Diabetes					
Heart Disease					
Osteoporosis					
Stroke (or other blood clotting disorders)					
Other					

SOCIAL

Please place an "X" in the relevant boxes

	Past	Daily	Weekly	Monthly	Rarely or NO
Alcohol					
Tobacco					
Recreational Drugs					
Caffeine					
Exercise and type					
Toxic Exposures through work or hobby					

DIET

Do you follow a special diet? [ ] No [ ] Yes (If yes, specify)

Do you avoid any foods? [ ] No [ ] Yes (If yes, specify)

How much water do you drink per day?					
Please list the typical foods you eat for:					
Breakfast:					
Lunch:					
Dinner:					
Snacks:					

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OTHER MEDICAL HISTORY AND REVIEW OF SYMPTOMS

Please write "C" for current symptoms or "P" for past symptoms and provide date where applicable.

	GENERAL
	Fatigue
	Weight Loss
	Weight Gain
	Fever / Chills
	Night Sweats
	Weakness

	SKIN
	Rash
	Itching
	Dryness
	Color Changes
	Moles
	Excessive Sweat
	Hair Loss
	Nail Changes
	Eczema / Psoriasis
	Easy Bruising

	EENT
	Eye Pain
	Eye Discharge
	Vision Changes
	Glasses / Contacts
	Double Vision
	Glaucoma
	Ear Infections
	Post Nasal Drip
	Sinus Congestion
	Hay Fever
	Bloody Nose
	Mouth Sores
	Bleeding Gums
	Sore Throat
	Difficult to Swallow

	IMMUNOLOGICAL
	Swollen Glands / Lymph Nodes
	Increased Infections
	Autoimmune Diseases

	BLOOD
	Anemia / Other Low Blood Counts
	Bleeding Disorders
	Blood Transfusion(s) Dates:___________

	LUNGS
	Cough
	Wheezing
	Short of Breath
	Asthma
	Bronchitis
	Painful Breathing
	Sputum Production / Bloody Sputum
	Tuberculosis Exposure
	Positive TB Skin Test

	HEART
	Heart Murmur
	Palpitations
	Chest Pain
	Ankle Swelling
	Hypertension
	High Cholesterol

	GASTROINTESTINAL
	Heartburn / Reflux
	Constipation
	Diarrhea
	Nausea / Vomiting
	Poor Appetite
	Hemorrhoids
	Black or Bloody Stool
	Abdominal Pain
	Change in Stool
	Gall Stones
	Hernia
	Colonoscopy Date:________________

	URINARY
	Painful Urination
	Weak Urine Stream
	Blood in Urine
	Kidney Infections
	Nighttime Urination
	Leaking Urine
	Bladder Infection

	ENDOCRINE
	High Blood Sugar / Diabetes
	Thyroid Problems
	Intolerance to Heat
	Excessive Thirst or Urination
	Excessive Sweating

	MUSCULOSKELETAL
	Joint Pain
	Muscle Tension
	Back Pain
	Muscle Cramps
	Bone Pain
	Osteoporosis Osteopenia

	NEUROLOGICAL
	Dizziness
	Vertigo
	Headaches
	Tingling / Numbness
	Tremors
	Impaired Balance or Coordination
	Memory Loss

	PSYCHOLOGICAL
	Anxiety
	Depression
	Mood Swings
	Difficulty Sleeping

	GYNECOLOGICAL
	Still Having Periods
	# of Pregnancies___________________
	# of Deliveries____________________
	Last Gyn Exam Date:_______________
	Last Mammogram Date:_____________
	Hormone Therapy