

Patient Name \_\_\_\_\_

**ARE YOU CURRENTLY DIAGNOSED WITH OR BEING TREATED FOR: (PLEASE CIRCLE ALL THAT APPLY)**

Blindness                      Deafness/Hard of Hearing                      Tension headache migraine  
Epilepsy/Seizures                      Paraplegia/Quadriplegia  
Angina                      Mitral Valve Prolapse                      Heart Attack                      High Blood Pressure  
Congestive Heart Failure                      Stroke                      Atrial Fibrillation                      Rheumatic fever  
HIV/AIDS                      Poor Blood Clotting                      Anemia                      Sickle Cell Anemia  
Asthma                      COPD/Emphysema                      Tuberculosis                      Pneumonia  
Arthritis                      Fibromyalgia                      Lupus  
Colitis                      Colon Polyp                      Cirrhosis of Liver                      Diverticulitis  
Gallstones                      Hepatitis                      Stomach Ulcers                      Pancreatitis  
Thyroid disorder                      Diabetes  
Pregnancy                      Urinary Incontinence                      Kidney Failure  
**CANCER:**      Skin      Brain      Mouth      Throat      Lung      Breast      Stomach      Colon      Bladder  
                    Kidney      Ovary      Uterine      Bone      Muscle      Melanoma  
Drug addiction                      Alcoholism

**For Children history of:**      Pregnancy difficulty                      Premature birth                      Developmental delay  
                    Speech delay      Hyperactivity      Bed wetting      Ear infections      Snoring      Imbalance  
                    Environmental allergies

**Please Circle all of the Surgeries you have had:**

Eye, Ear, Nose:      Glaucoma                      Cataract                      Septoplasty      Rhinoplasty      Sinuses                      Tonsillectomy  
                    UPPP                      Cleft palate      Other  
Neck:                      Larynx                      Thyroid                      Carotids                      Other  
Orthopedic:                      Cervical spine                      Spine other                      Joint repair                      Joint replacement                      Other  
Heart:                      valve                      stent                      bypass                      other  
Lung:                      lobe                      Other  
Abdomen:                      Liver                      Spleen                      Stomach                      Kidney                      Bladder  
                    Gall bladder                      Colon                      Ovarian                      Hysterectomy      Prostrate                      Other  
Skin cancer      Other

Please Circle all of the symptoms listed below you currently have:

- **General**

Easy bruising      Fatigue      Fever      Hair loss      Excessive hair growth  
Intolerance to heat/cold      Night sweat      Shakiness      sweating  
Weight loss      weight problem

- **Skin**

Acne    Rash    Warts    Sensitive to sun    Nail changes      New lesions/moles

- **Eye, Ear, Nose & Throat**

Vision Changes      Ear Ringing      Hearing difficulties      Allergies/ Hay fever  
Runny nose/congestion      Sinus infections      Hoarseness      Swollen lymph glands

- **Respiratory/Lung**

Cough      Coughing blood      Shortness of breath      Snoring      Wheezing

- **Cardiovascular/Heart**

Chest pain/pressure    Ankle swelling    Blood clots    Lightheaded spells    Irregular heart beat

- **Gastrointestinal**

Indigestion/Heartburn      Abdominal pain      Nausea      Vomiting    Blood in stool  
Constipation      Diarrhea      Difficulty swallowing

- **Urinary system**

Frequent urination      Burning on urination    Blood in urine      Urinary hesitancy

- **Gynecological**

Irregular periods      Menopausal concerns      Hot flashes      Infertility

- **Musculoskeletal**

Back pain      Joint pain/stiffness      Leg pain      Muscle weakness

- **Mental Health**

Anxiety      Mood Changes      Difficulty concentrating      Insomnia      Tension/Stress

- **Neurological**

Memory loss    Dizziness      Loss of sensation      Tremor      Headaches/severe

**Family History:**

Hypertension: father mother sibling grandmother grandfather  
Heart disease: father mother sibling grandmother grandfather  
Stroke: father mother sibling grandmother grandfather  
Diabetes: father mother sibling grandmother grandfather  
COPD: father mother sibling grandmother grandfather  
Thyroid Disease: father mother sibling grandmother grandfather  
Head and Neck cancer: father mother sibling grandmother grandfather  
Other cancer: father mother sibling grandmother grandfather  
Hearing loss: father mother sibling grandmother grandfather  
Dizziness: father mother sibling grandmother grandfather

**Social History:**

Marital Status: Single Married Divorced  
Employment: Full time Part time Unemployed Homemaker Retired Student  
Exercise: Regularly Occasional Never  
Smoking: Never Quit Recently Quit>5yrs Occasional Daily  
Alcohol Drinks/wk: Never 1-3 4-7 8+  
Illicit drugs: Never Former Current

Depression: Over the past 2 weeks feeling down, depressed, or hopeless OR little interest or pleasure in doing things? Yes No

