PATIENT NAME: ____________________________________DOB:_____________________ DATE:___________________________

PLEASE INDICATE DETAILED REASON(S) FOR THIS VISIT:

____
____
____

HOW LONG HAVE YOU HAD THESE PROBLEMS? ___________________________________

WHAT OTHER DOCTORS HAVE YOU SEEN? ____
____

WHAT MEDICATIONS DO YOU TAKE? ____
____
____

DO YOU HAVE ANY ALLERGIES? ____

DO YOU HAVE ANY IMPAIRMENT (SPEECH, VISUAL, HEARING, ETC?) ____

DO YOU:	SMOKE	YES / NO
	DRINK	YES / NO
	TAKE DRUGS	YES / NO

ARE YOU ON A SPECIAL DIET? YES / NO

DO YOU HAVE ANY RELIGIOUS OR CULTURAL RESTRICTIONS THAT THE DOCTOR SHOULD KNOW ABOUT? _________

____

DO YOU HAVE A "LIVING WILL" OR ADVANCED DIRECTIVES? YES/NO

WHAT LANGUAGE(S) DO YOU SPEAK, READ OR WRITE:____

WERE YOU REFERRED? YES/ NO BY WHOM: ______________________________________

HAVE YOU EVER BEEN SUSPECTED OF HAVING THE FOLLOWING – (PLEASE CIRCLE)

	PATIENT	FAMILY	WHICH RELATIVE (BROTHER,MOTHER,ETC.)
DIABETES	YES / NO	YES / NO	_________________
HYPERTENSION	YES / NO	YES / NO	_________________
HEART DISEASE	YES / NO	YES / NO	_________________
ARTHRITIS	YES / NO	YES / NO	_________________
BLOOD CLOTS	YES / NO	YES / NO	_________________
KIDNEY PROBLEMS	YES / NO	YES / NO	_________________
STROKE	YES / NO	YES / NO	_________________
TUMOR	YES / NO	YES / NO	_________________
NEUROLOGICAL PROBLEMS	YES / NO	YES / NO	_________________
HEADACHES	YES / NO	YES / NO	_________________
OTHER:	______________________________________	YES / NO	_________________

PATIENT NAME: ____________________________________DOB:_____________________ DATE:___________________________

PLEASE CHECK ANY OF THE FOLLOWING SYMPTOMS YOU MAY HAVE

HEAD, EARS, EYES, NOSE, THROAT		**MUSCULAR/SKELETAL**		**INTESTINES**	
HEADACHES	☐	JOINT PAIN	☐	NAUSEA, VOMITING	☐
HEARING LOSS	☐	LIMITED MOTION	☐	DIARRHEA, CONSTIPATION	☐
RINGING EARS	☐	BACK PAIN	☐	ABDOMEN PAIN	☐
VISUAL CHANGES	☐	MUSCLE ACHES & PAINS	☐	WEIGHT CHANGE	☐
SORE THROAT	☐	MUSCLE WEAKNESS	☐	APPETITE CHANGE	☐
NOSE BLEEDS	☐			JAUNDICE	☐
NONE OF THE ABOVE	☐	NONE OF THE ABOVE	☐	NONE OF THE ABOVE	☐

URINARY		**CARDIAC/RESPIRATORY**		**SKIN**	
URINARY FREQUENCY	☐	CHEST PAIN	☐	RASH	☐
BLOOD IN URINE	☐	BLUE LIPS, NAIL BEDS	☐	ITCHING	☐
LITTLE OR NO URINE	☐	DIFFICULTY BREATHING	☐	SORES	☐
STONES	☐	COUGH	☐	TEMP. WARM/CLAMMY	☐
PUS IN URINE	☐	SPUTUM	☐	FLUID RETENTION	☐
INCONTINENCE	☐	VARICOSE VEINS	☐		
NONE OF THE ABOVE	☐	NONE OF THE ABOVE	☐	NONE OF THE ABOVE	☐

NEUROLOGICAL

HEADACHES	☐	CONVULSIONS	☐	DIZZINESS	☐
SPEECH DIFFICULTY	☐	TREMORS	☐	PARALYSIS	☐
EQUILIBRIUM (BALANCE)	☐	NUMBNESS	☐	SENSORY LOSS	☐
LOSS OF SLEEP	☐	DREAMS/NIGHTMARES	☐	ANXIOUSNESS	☐
		LOSS OF VISION	☐		

FAMILY HISTORY

NUMBER OF CHILDREN: __________

MOTHER LIVING ☐ DECEASED ☐ CAUSE OF DEATH ___________________________

FATHER LIVING ☐ DECEASED ☐ CAUSE OF DEATH ___________________________

BROTHERS _____ LIVING ☐ DECEASED ☐ CAUSE OF DEATH ___________________________

SISTERS _____ LIVING ☐ DECEASED ☐ CAUSE OF DEATH ___________________________

COMMENTS OR ADDITIONAL INFORMATION:

____
____
____