Patient Name: _____ DOB: _____ Date of Visit: _____

If a physician (or other healthcare provider) referred you for today's visit, then please indicate their name here:

_____

Reason for today's visit: _____

_____

YOUR CURRENT SYMPTOMS

Please check the appropriate box(es) for any symptoms you are experiencing now.

General
- ☐ Dizziness
- ☐ Fever

Skin
- ☐ Itching Skin

Head, Ears, Eyes, Nose & Throat
- ☐ Hoarseness
- ☐ Sore throat

Respiratory
- ☐ Cough
- ☐ Difficulty breathing

Cardiovascular
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ Swelling of extremities

Digestive Tract
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood or coffee grounds
- ☐ Bloating or swelling
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody or tar-like stool
- ☐ Anal or rectal pain
- ☐ Difficult or painful swallowing
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Weight loss
- ☐ Jaundice (yellow skin or eyes)

Urinary Tract
- ☐ Urinating frequently
- ☐ Urgent need to urinate
- ☐ Loss of control of urination

Musculoskeletal
- ☐ Joint pain

Neurological
- ☐ Confusion
- ☐ Excessive drowsiness

Psychiatric
- ☐ Anxiety
- ☐ Depression

Endocrine
- ☐ Cold intolerance
- ☐ Heat intolerance

Hematology
- ☐ Easy bruising
- ☐ Enlarged lymph nodes

Male Conditions
- ☐ Prostate problems

Female Conditions
- ☐ Abnormal vaginal bleeding
- ☐ Menopausal symptoms

None of the above
- ☐

IMMUNIZATION:

Flu Shot *Yes* ☐ *No* ☐

Pneumonia Shot *Yes* ☐ *No* ☐

Patient Name: _____ **DOB:** _____ **Date of Visit:** _____

YOUR PERSONAL MEDICAL HISTORY

Please check the appropriate box(es) for your past or ongoing medical conditions.

- ☐ Allergic rhinitis
- ☐ Anticoagulation (blood thinner therapy)
- ☐ Anxiety/depression
- ☐ Asthma
- ☐ Barrett's esophagus
- ☐ Bleeding disorder
- ☐ Blood clots (location in body _____)
- ☐ Breast cancer
- ☐ Celiac disease or sprue
- ☐ Chronic renal failure syndrome
- ☐ Colon cancer
- ☐ Colon polyps
- ☐ Congestive heart failure
- ☐ Coronary artery disease
- ☐ Coronary artery stent placement
- ☐ Crohn's disease
- ☐ Diabetes mellitus
- ☐ Dialysis (peritoneal or hemodialysis)
- ☐ Diverticulosis
- ☐ Diverticulitis (infected diverticulosis)
- ☐ Emphysema
- ☐ Esophageal cancer
- ☐ Esophageal reflux disease (GERD)
- ☐ Esophageal varices
- ☐ Fatty liver
- ☐ Gallbladder stones or disease
- ☐ Gastritis
- ☐ Glaucoma
- ☐ Gout
- ☐ Hemorrhoids
- ☐ Hepatitis (type, if known _____)
- ☐ Hiatal hernia
- ☐ History of Helicobacter pylori infection
- ☐ High blood pressure or hypertension
- ☐ High cholesterol
- ☐ HIV (human immunodeficiency virus)
- ☐ Home oxygen
- ☐ Hyperthyroidism
- ☐ Hypothyroidism
- ☐ Insulin therapy
- ☐ Iron deficiency anemia
- ☐ Irritable bowel syndrome
- ☐ Lactose intolerance
- ☐ Liver cancer
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Osteoporosis
- ☐ Pancreatitis
- ☐ Pancreatic cancer
- ☐ Personal history of bowel obstruction
- ☐ Prostate cancer
- ☐ Radiation therapy for prostate cancer
- ☐ Rheumatoid arthritis
- ☐ Schizophrenia
- ☐ Seizure disorder
- ☐ Sleep apnea (do you require C-PAP _____)
- ☐ Stomach or duodenal ulcer
- ☐ Stroke (cerebrovascular accident)
- ☐ TIA (transient ischemic attack)
- ☐ TB (tuberculosis)
- ☐ Ulcerative colitis
- ☐ Valvular heart disease

- ☐ None of the above

SOCIAL HISTORY

Please check the appropriate box(es) for your social history that applies.

Tobacco:

- ☐ Cigarettes: _____Day
- ☐ Never smoked

Alcohol: Yes ☐ No ☐

Use of recreational drugs or substances
(Name of substance or drug): _____

FAMILY HISTORY

Please check the appropriate box(es) for any important medical disorders that could be inherited from your close family member relationships (such as father, mother, sister or brother).

Please list family member:

- ☐ Heart disease _____

☐ Hepatitis _____

☐ Bleeding disorder_____

☐ Pancreatic disease _____

☐ Colon polyps_____

☐ Ulcerative colitis _____

☐ Crohn's disease _____

☐ Colon cancer_____

☐ Other_____

☐ None of the above