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

If a physician or other healthcare provider referred you for today's visit, please indicate their name on the line below:

_____

Reason for today's visit: _____

Location: _____ **Severity (Scale 1-10)** 10 **Duration (how long)** _____ **Timing (when it occurs)** _____

YOUR CURRENT SYMPTOMS

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

General
- ☐ Fainting
- ☐ Dizziness
- ☐ Fever
- ☐ Weakness
- ☐ Feeling tired

Skin
- ☐ Itching Skin
- ☐ Rash on Skin

Head, Ears, Eyes, Nose & Throat
- ☐ Blurry vision
- ☐ Worsening vision
- ☐ Ringing in the ears
- ☐ Loss of hearing
- ☐ Hoarseness
- ☐ Sore throat

Respiratory
- ☐ Cough
- ☐ Bloody sputum
- ☐ Difficulty breathing
- ☐ Wheezing

Cardiovascular
- ☐ Chest pain or discomfort
- ☐ Irregular heartbeat
- ☐ Leg pain when walking
- ☐ Swelling of extremities

Digestive Tract
- ☐ Abdominal pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting blood or coffee grounds
- ☐ Bloating or swelling
- ☐ Excess or foul belching
- ☐ Passing excess or foul gas
- ☐ Constipation
- ☐ Diarrhea
- ☐ Bloody or tar-like stool
- ☐ Leakage of stool or mucous from anus
- ☐ Anal or rectal pain
- ☐ Difficult or painful swallowing
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Weight loss of _____ pounds
- ☐ Weight gain of _____ pounds
- ☐ Jaundice (yellow skin or eyes)

Urinary Tract
- ☐ Blood in urine
- ☐ Burning upon urination
- ☐ Urinating frequently
- ☐ Delay/difficulty urinating
- ☐ Urgent need to urinate
- ☐ Loss of control of urination

Musculoskeletal
- ☐ Back pain
- ☐ Joint pain
- ☐ Muscle pain

Neurological
- ☐ Headaches
- ☐ Numbness
- ☐ Localized muscle weakness
- ☐ Confusion
- ☐ Excessive drowsiness

Psychiatric
- ☐ Anxiety
- ☐ Disorientation
- ☐ Depression
- ☐ Sleep disturbance
- ☐ Memory loss

Endocrine
- ☐ Cold intolerance
- ☐ Excessive thirst
- ☐ Heat intolerance
- ☐ Excessive urination

Hematology
- ☐ Easy bruising
- ☐ Enlarged lymph nodes

Male Conditions
- ☐ Prostate problems
- ☐ Impotence

Female Conditions
- ☐ Menstrual problems
- ☐ Abnormal vaginal bleeding
- ☐ Menopausal symptoms
- ☐ Breast lumps
- ☐ Breast discharge

☐ **None of the above**

Immunizations: Flu 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
- ☐ Anal warts
- ☐ 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
- ☐ COPD (chronic obstructive pulmonary disease)
- ☐ Coronary artery disease
- ☐ Coronary artery stent placement
- ☐ Crohn's disease
- ☐ Diabetes mellitus
- ☐ Dialysis (peritoneal or hemodialysis)
- ☐ Diverticulosis
- ☐ Diverticulitis (infected diverticulosis)
- ☐ Elevated triglycerides
- ☐ Emphysema
- ☐ Esophageal cancer
- ☐ Esophageal reflux disease (GERD)
- ☐ Esophageal stricture
- ☐ Esophageal varices
- ☐ Fatty liver
- ☐ Fibromyalgia
- ☐ Gallbladder stones or disease
- ☐ Gastritis
- ☐ Genital herpes
- ☐ Glaucoma
- ☐ Gout
- ☐ Grave's disease
- ☐ 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
- ☐ Inguinal hernia
- ☐ Insulin therapy
- ☐ Iron deficiency anemia
- ☐ Irritable bowel syndrome
- ☐ Ischemic colitis
- ☐ Kidney stones
- ☐ Lactose intolerance
- ☐ Liver cancer
- ☐ Lung cancer
- ☐ Lymphoma
- ☐ Migraine headaches
- ☐ Osteoarthritis
- ☐ Osteoporosis
- ☐ Osteopenia
- ☐ Pancreatitis
- ☐ Pancreatic cancer
- ☐ Pernicious anemia
- ☐ Personal history of bowel obstruction
- ☐ Prostate cancer
- ☐ Prostate enlargement
- ☐ Radiation therapy for prostate cancer
- ☐ Rheumatoid arthritis
- ☐ Schizophrenia
- ☐ Seizure disorder
- ☐ Sinusitis
- ☐ Sleep apnea (do you require C-PAP _____)
- ☐ Stomach or duodenal ulcer
- ☐ Stroke (cerebrovascular accident)
- ☐ TB (tuberculosis)
- ☐ TIA (transient ischemic attack)
- ☐ Transfusion of blood or blood products
- ☐ 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
- ☐ Cigars: _____ Day
- ☐ Snuff: _____ Day
- ☐ Chew: _____ Day
- ☐ Recently quit _____
- ☐ Never smoked

Alcohol:

Type: _____

- ☐ Amount: _____
- ☐ Years: _____
- ☐ Never consumed:

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