Patient history

Patient Name:_____ Date:_____

Current Medications	Dosage

Patient History	Patient		Family	
	Yes	No	Yes	No
Arthritis				
Diabetes				
Hypertension				
Heart Disease				
DVT or Blood Clots				
Lung Disease				
Liver Disease				
Kidney Disease				
Seizure or Stroke				
Thyroid Disease				
Tumors or Cancer				
Ulcers				

Past Surgical History

Operations	**Date**

Drug Allergies:

Social History

1.Do you use tobacco?	**YES**	**NO**
Packs Per Day?	Years Smoking?	
2.Alcohol	**YES**	**NO**

Review of System: Are you Experiencing Any Problems Regarding:		Yes	No
Neurological	Dizziness		
	Fainting		
	Weakness		
	Numbness		
Respiratory	Coughing		
	Fevers		
	Shortness Breath		
Cardiac			
	Chest Pain, Tightness		
	Palpitations		
	Fevers		
Genitourinary			
	Burning w/Urine		
	Frequent Urination		
	Night Urination		
Gastrointestinal	Nausea, Vomiting		
	Diarrhea		
	Black Stool		
	Abdominal Pain		
	Weight Loss		
Musculoskeletal	Swelling of Legs		
	Swelling of Joints		
	Pain Back/Neck		
	Pain when Walking		
Skin/Rashes	Rashes or Hives		
General	Weight Gain		
	Sleep Problems		
	Depression		
	Fever/Chills		
	Weight Loss		

Patient Signature:_____