

ADULT

NAME _____ Date of birth _____ Today's date _____

Prescriptions & doses: NONE _____ Primary Care MD _____ ph# _____

_____ Person who sent you _____

_____ Local pharmacy _____ ph# _____

All other medicines (examples: Aspirin, Motrin, herbs, vitamins): NONE _____

Drug allergy: NONE KNOWN _____

List previous surgeries and when: NONE tonsils _____ ear tubes _____ ear _____ nose _____ dental _____

bypass _____ hernia _____ hysterectomy _____ other _____

Do you smoke or chew tobacco? YES NO How much daily? _____ When did you quit? _____

Employed? YES NO retired job description: _____ student

Your weight _____ lbs. your height _____

Have you had any of the following problems? (Please circle an answer for every question)

<u>Constitutional</u>			<u>Hematological / Lymphatic</u>			<u>Musculoskeletal</u>		
HIGH BLOOD PRESSURE	YES	NO	ANEMIA	YES	NO	ARTHRITIS	YES	NO
<u>Eyes</u>			BLEEDING DISORDER			<u>Endocrine</u>		
EYE PROBLEM (not glasses)	YES	NO	EASY BRUISING	YES	NO	THYROID DISORDER	YES	NO
<u>Ears, nose, throat</u>			BLOOD DONATION REFUSED			DIABETES		
HEARING LOSS	YES	NO	BLOOD TRANSFUSION	YES	NO	<u>Allergy/Immunology</u>		
RINGING IN EAR(S)	YES	NO	BLOOD CLOTS	YES	NO	ALLERGY TESTING	YES	NO
<u>Cardiovascular</u>			SWOLLEN GLANDS			react to _____		
CHEST PAIN (ANGINA)	YES	NO	<u>Skin</u>			HAYFEVER		
HEART MURMUR	YES	NO	HERPES INFECTION/SHINGLES	YES	NO	<u>General</u>		
RHEUMATIC FEVER	YES	NO	ECZEMA	YES	NO	CANCER or other tumors		
HEART ATTACK	YES	NO	SKIN CANCER	YES	NO	where/when _____		
VALVE IMPLANT	YES	NO	where/when _____			treatment _____		
PACEMAKER	YES	NO	<u>Neurologic</u>			Any other medical problem(s) _____		
<u>Respiratory</u>			MIGRAINE HEADACHES			YES	NO	
ASTHMA	YES	NO	EPILEPSY OR SEIZURE			YES	NO	
SLEEP APNEA	YES	NO	STROKE			YES	NO	
<u>Gastrointestinal</u>			NUMBNESS/TINGLING			YES	NO	
STOMACH ULCER	YES	NO	<u>Psychiatric</u>			<u>Women only</u>		
Hepatitis, jaundice, cirrhosis	YES	NO	DEPRESSION			YES	NO	PREGNANT/NURSING NOW
<u>Genitourinary</u>			ANXIETY/ PANIC ATTACKS			YES	NO	PAST YEAST INFECTIONS
PROSTATE PROBLEM	YES	NO	CLAUSTROPHOBIA			YES	NO	
FREQUENT URINATION	YES	NO	ALCOHOL/DRUG DEPENDENCY			YES	NO	Reviewed by / Date
			stopped use			YES	NO	Reviewed by / Date

Family History: Tonsillitis: YES NO Hearing Loss: YES NO Sinusitis: YES NO Allergies: YES NO Bleeding disorder: YES NO

List any other family medical problems _____

Have you had any of the following symptoms within the last 6 months? (please answer every question)

WT CHANGE (> 5 LBS)	YES	NO	SINUS INFECTION	YES	NO	NAUSEA / VOMITING	YES	NO
INTENSE HEADACHES	YES	NO	POSTNASAL DRIP	YES	NO	HEARTBURN	YES	NO
FEVER / CHILL	YES	NO	COUGH	YES	NO	DIARRHEA	YES	NO
DIZZINESS	YES	NO	LOSS OF VOICE	YES	NO	CONSTIPATION	YES	NO
EAR PAIN	YES	NO	LOUD SNORING	YES	NO	RECENT DENTAL WORK	YES	NO
EAR DRAINAGE	YES	NO	SLEEP APNEA	YES	NO	RECENT TOOTH PAIN	YES	NO
NASAL BLOCKAGE	YES	NO	DIFFICULTY BREATHING	YES	NO	MOUTH SORES	YES	NO
LOSS OF SMELL	YES	NO	DIFFICULTY SWALLOWING	YES	NO	NONHEALING SKIN SORE	YES	NO
NOSEBLEEDS	YES	NO	LUMP IN THROAT	YES	NO	RASH/ SKIN LESION	YES	NO