MEDICAL HISTORY / Review of Systems: *Please complete blanks below and mark any conditions that apply to you.*

Name:_____ **Date:** _____

Your Primary Care Physician's Name: _____ and their phone: (_____) _____
Were you REFERRED to us by another DOCTOR? Y N
Dr's Name_____ Phone (___) _____
Their Address_____

List your ALLERGIES to medicine or any other substance

_____
_____
_____
_____

List your MEDICATIONS Vitamins, Pills and Supplements you take and what they are for:

_____
_____
_____
_____
_____
_____
_____
_____

FAMILY HISTORY:
List *anyone in your family who has these disorders.*
Diabetes _____
High Blood Pressure _____
Stroke_____
Heart Disease _____
Macular degeneration _____
Glaucoma _____
Other _____

SURGERIES: Please list any surgeries you have had, and during what month and year.

_____
_____
_____
_____
_____

SOCIAL HISTORY: (Circle the best answer)

Tobacco Use? Current / Former / Never
When did you quit? 1 2 3 4 5 6+ years ago
Alcohol Use? None / Rarely / Daily / Frequent
Narcotic use? None / Rarely / Daily / Frequent

Birth Order: 1 2 3 4 5
Were You: Only child? / Fraternal twin? / Identical twin?
History of Blood Transfusion Y N
Approximate: Height _____ Weight _____

Cardiovascular
___ Heart Attack
___ High Blood Pressure
___ Congestive Heart Failure
___ Elevated Cholesterol
___ Stroke
Other_____

Constitutional
___ Appetite Loss/ Excess
___ Dizziness
___ Fainting
___ Fatigue
___ Nausea
___ Poor Sleep
___ Thirst Excess
Other_____

Endocrine
___ Diabetes
___ Hypoglycemia
___ Hepatitis
___ Thyroid Disorder
___ Pituitary Disorder
Other _____

Gastrointestinal
___ Reflux Disorder (GERD)
___ Nausea
___ Weight Gain/ Loss
___ Gallbladder / stones
___ Colon Cancer
___ Crohn's Disease
Other_____

Genitourinary
___ Kidney Disease/Infection
___ Bladder Disease/ Infection
___ Uterine Cancer
___ Sexually Transmitted Disease
___ Prostate Enlarged / Cancer
___ Kidney Disorder
___ Kidney Stones
___Prostate Disorder
Other_____

__ Head
__ Headaches / Migraines
__ Dental disorder
__ Hearing Loss
__ Seizures
Other _____

Hematologic /Lymphatic
___ Breast Cancer
___ Hodgkin's Lymphoma
___ Sickle Cell Disease
___ Leukemia
___ Bleeding Disorder
___ Temporal Arteritis
___ Peripheral Vascular Disease
Other _____

Immunologic / Infectious
___ Cancer
___ HIV
___ Bacterial Infection
___ Viral Infection (Herpes etc)
___ Mononucleosis
___ Lyme Disease
___ Sarcoid
___ Sjogren's Syndrome
Other_____

Integumentary/Skin
___ Albinism
___ Dermatitis
___ Lupus
___ Raynaud's
___ Rosacea
___ Scleraderma
___ Skin Cancer
___ Urticaria (hives)
Other_____

Musculoskeletal
___ Arthritis
___ Down's Syndrome
___ Gout
___ Marfan's Syndrome
___ Muscular Dystrophy
___ Myasthenia Gravis
___ Osteoporosis
___ Paget's Disease
___ Scoliosis
___ Skeletal Disorder
Other _____

Neurologic
___ Alzheimer's
___ Brain Tumor / Damage
___ Cerebral Palsy
___ Epilepsy
___ Multiple Sclerosis
___ Myasthenia Gravis
___Seizures
___ Neuralgia / fibromyalgia
___Parkinson's
Other _____

Psychiatric
___ Attention Deficit (ADD)
___ Anorexia
___ Autism
___ Anxiety
___ Bipolar
___ Dementia
___ Depression
___ Insomnia
___ Memory Loss
___ Mood Disorder
___ Schizophrenia
Other _____

Respiratory
___ Cough
___ Asthma
___ Bronchitis
___ Pneumonia
___ Cystic Fibrosis
___ Emphysema
___ Tuberculosis
Other _____