Affix Patient Label Here

Current Medications:

❒ No Medications

1. ____________________ Dosage: ______________________
2. ____________________ Dosage: ______________________
3. ____________________ Dosage: ______________________
4. ____________________ Dosage: ______________________

Please continue your list on an additional page, if needed.

Drug Allergies:

❒ No Allergies

1. ____
2. ____
3. ____
4. ____

Please continue your list on an additional page, if needed.

Vision:

Have you ever experienced vision problems?
❒ Yes ❒ No

If Yes, please describe:_______________________________

Do you wear glasses or contacts? ❒ Yes ❒ No

Last Eye Exam? ____
By whom? ____

Surgical History:

Procedure:____
Performed by:____
Date:____

Procedure:____
Performed by:____
Date:____

Procedure:____
Performed by:____
Date:____

Have you experienced problems with Anesthesia?
❒ Yes ❒ No

If Yes, please describe:_______________________________

Affix Patient Label Here

Physical Exam:

Date of your most recent physical:____________________________
Completed by:____
Date of most recent EKG:___________________________________
Date of most recent Stress EKG:_____________________________
Date of most recent Chest X-Ray:____________________________

Do you sleep well? ❐ Yes ❐ No

Significant Family Medical History:

____

____

____

____

Significant Personal Medical History:

____

____

____

____

Review of Symptoms: (check all that apply)

History of:	Current Symptom:	Condition:	Explanation:
❐	❐	CNS, Stroke, Migraines, Headaches	____________________
❐	❐	Psychological, Emotional, or Stress Disorders	____________________
❐	❐	Eye, Ear, Nose, Throat, or Sinus Problems	

History of:	Current Symptom:	Condition:	Explanation:
❐	❐	Neck Pain	
❐	❐	Birth Defects: cleft lip, cleft palate, etc.	
❐	❐	Dental or tooth-related problems	
❐	❐	Pulmonary, Emphysema, Airway or Breathing Problems	
❐	❐	Cardiovascular Problems	
❐	❐	Endocrine, Thyroid, Gland Problems	
❐	❐	Liver Problems	
❐	❐	Bleeding or Blood Clotting Problems, Anemia	
❐	❐	Kidney, Urinary, or Prostate Problems	
❐	❐	Gastrointestinal, Bowel Problems	
❐	❐	Musculoskeletal, Breaks / Fractures, Arthritis	
❐	❐	Back Pain	
❐	❐	Obstetrical, Gynecological	
❐	❐	Chronic Fatigue Syndrome	
❐	❐	Dermatologic, Skin Problems, Skin Cancer	
❐	❐	Cancers, Malignancy	
❐	❐	Sexually Transmitted Disease	
❐	❐	Anorexia / Bulimia, Dietary Medications, Weight Loss Medications / Restrictions	
❐	❐	Recent Medical Problem / Infection In The Last 7 Days	
❐	❐	Other	