MEDICAL HISTORY & REVIEW OF SYMPTOMS: Please check all that apply
Do you currently have or have you had in the past any problems related to the following systems?

Past Surgeries

- □ Tonsillectomy
- □ Heart bypass
- □ Hysterectomy
- □ Knee replacement
- □ Appendectomy
- □ Gall Bladder
- □ Hip replacement
- □ Rotator cuff repair
- □ Spine surgery
- □ ___________________________
- □ ___________________________

Social History

Do you smoke? □Yes □ No
packs/day ______________________
Former Smoker? □Yes □ No
Year Quit smoking ________________
How soon after you wake up do you smoke your first cigarette? ________________
Are you interested in quitting? □Yes □ No

Do you drink alcohol? □Yes □ No
How much per week? _______________
____

Family History

Is your **mother** living? □Yes □ No
List medical problems/cause of death
____
____

Is your **father** living? □Yes □ No
List medical problems/cause of death
____
____

Skin

- □ itching/dryness
- □ bruising
- □ breast disease
- □ rashes

□ **None of the above/negative**

General/Constitutional

- □ Chills
- □ Significant weight gain
- □ Cancer
- □ Night Sweats
- □ Weight loss
- □ Fatigue
- □ Fever
- □ **None of the above/negative**

Endocrine/Hematologic/Immunologic

- □ anemia
- □ excessive thirst
- □ appetite change
- □ Diabetes
- □ easy bleeding/bleeding disorder
- □ blood transfusion
- □ Cold Intolerance
- □ Frequent urination
- □ Heat Intolerance
- □ Osteopenia
- □ Osteoporosis
- □ Thyroid Problems

□ **None of the above/negative**

Musculoskeletal

- □ Arthritis
- □ Joint Stiffness
- □ Fibromyalgia
- □ Joint Swelling
- □ Joint Pain

□ **None of the above**

Psychological

- □ ADHD □ Anxiety
- □ Bipolar Disorder □ Depression
- □ Nervousness □ OCD

□ **None of the above/negative**

Genitourinary

- □ Stool Incontinence
- □ Urinary tract Infections
- □ Urinary Incontinence
- □ Kidney Stones
- □ Bloody stools
- □ Prostate disorder

□ **None of the above/negative**

Eyes, ears, nose and throat

- □ Double vision
- □ Glaucoma
- □ Sore throats
- □ Poor hearing
- □ Glasses/contacts
- □ Frequent nose bleeds
- □ Hearing aide __ R __ L __ Both
- □ Hoarseness
- □ Sinus Infections
- □ **None of the above/negative**

Respiratory

- □ Frequent or chronic cough
- □ Shortness of breath
- □ Tuberculosis
- □ Lung Disease
- □ Coughing up Phlegm
- □ COPD
- □ Asthma
- □ Coughing up blood
- □ Wheezing
- □ **None of the above/negative**

Cardiovascular

- □ Breathlessness
- □ Heart attack
- □ Edema/Swelling hands
- □ Heart murmur
- □ Phlebitis
- □ Chest pain or angina
- □ Peripheral vascular disease
- □ Palpitations
- □ Blood clots
- □ Arrhythmia/irregular heart beat
- □ Pacemaker/Defibrillator
- □ High Blood Pressure
- □ High Cholesterol
- □ Heart Problems
- □ **None of the above/negative**

Neurologic

- □ Speech difficulties
- □ Stroke
- □ Numbness
- □ Seizures
- □ Tingling
- □ Dizziness
- □ Paralysis
- □ Migraine Headaches
- □ Lyme Disease

□ **None of the above/negative**

Gastrointestinal

- □ Reflux
- □ Abdominal pain
- □ Bloody Stool
- □ Nausea
- □ Hemorrhoids
- □ Vomiting
- □ Vomiting Blood
- □ Diarrhea
- □ Constipation
- □ Ulcers
- □ Heartburn
- □ Hepatitis
- □ Gall Stones
- □ IBS
- □ **None of the above/negative**

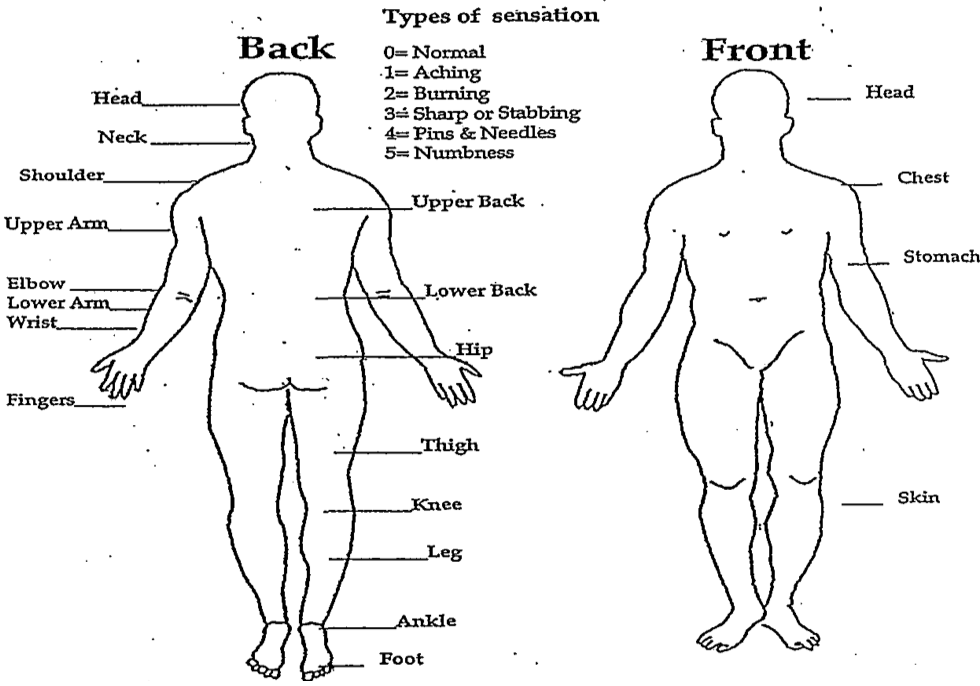
Print Name: ____ Date: ___________________

Please list your Medications: (Name of drug, dosage, frequency and *administration. i.e. by mouth, injection, topical, sublingual, etc.)

MEDICATION:	DOSAGE:	FREQUENCY:	*ADMINISTRATION:

Allergies	Infectious Disease	Fall Risk Screening
Drug Allergies: ____________________ ________________________________ ________________________________ ________________________________ ________________________________ **Latex Allergy**? Y / N	□ MRSA □ C-Diff □ Tuberculosis □ Other:____________ ________________________________ ________________________________ ________________________________ □ **None of the above/negative**	Please select one of the following related to the number of falls you had within the last year: □ No falls □ One fall with injury □ Two or more falls with injury □ One fall without injury □ Two or more falls without injury
Vitals		**Work Status**
Height: ___________ Weight: __________		Occupation: ___________________ □ Sedentary □ Heavy labor □ Retired □ Disabled

Use the diagram below to specify what symptoms you are experiencing and where they are located. Use the corresponding numbers to indicate the types of sensations you are experiencing in those locations.



Patient Signature: ________________________________ **Print Name:** ____________________________ **Date:**______________