Patient Name: ____ **Date of birth:**___/___/___

Today's Date:____/____/____ **Height:**______ **Weight:**______

Reasons for visit:_________________________________ **Duration of symptoms:**__________________________

Check negative or positive for any **current or recent** health problems below.

Constitutional: ALL NEGATIVE

Neg Pos
- ☐ ☐ Chills
- ☐ ☐ Fatigue
- ☐ ☐ Fever
- ☐ ☐ Weight loss
- ☐ ☐ Weight gain
- ☐ ☐ Night sweats

Other:____

Head, Eyes, Ears, Nose and Throat: ALL NEGATIVE

Neg Pos
- ☐ ☐ Blurred vision
- ☐ ☐ Choking on liquids
- ☐ ☐ Choking on solids
- ☐ ☐ Double vision
- ☐ ☐ Dizziness
- ☐ ☐ Drooling
- ☐ ☐ Trouble swallowing
- ☐ ☐ Ear drainage
- ☐ ☐ Hoarseness
- ☐ ☐ Mouth ulcers
- ☐ ☐ Ear pain; if positive:
  ☐ Left ☐ Right ☐ Both
- ☐ ☐ Sore throat
- ☐ ☐ Ringing/noise in ears; if positive:
  ☐ Left ☐ Right ☐ Both
  Describe:______________________________
- ☐ ☐ Vertigo
- ☐ ☐ Visual changes
- ☐ ☐ Hearing loss; if positive:
  ☐ Left ☐ Right ☐ Both
  ☐ Gradual ☐ Sudden
  How long have you noticed your hearing loss?
  ____

Other:____

Respiratory: ALL NEGATIVE

Neg Pos
- ☐ ☐ Apnea during sleep
- ☐ ☐ Cough
- ☐ ☐ Shortness of breath
- ☐ ☐ Snoring
- ☐ ☐ Wheezing

Other:____

Cardiovascular: ALL NEGATIVE

Neg Pos
- ☐ ☐ Chest pain
- ☐ ☐ Heart murmur
- ☐ ☐ Palpitations

Other:____

Gastrointestinal: ALL NEGATIVE

Neg Pos
- ☐ ☐ Abdominal pain
- ☐ ☐ Constipation
- ☐ ☐ Diarrhea
- ☐ ☐ Heartburn
- ☐ ☐ Vomiting

Other:____

Genitourinary: ALL NEGATIVE

Neg Pos
- ☐ ☐ Change in urine color
- ☐ ☐ Painful urination
- ☐ ☐ Urinary frequency

Female patients only:

Neg Pos
- ☐ ☐ Are you pregnant?

Date of last menstrual period: ______________________

Other:____

Metabolic/Endocrine: ALL NEGATIVE

Neg Pos
- ☐ ☐ Cold intolerance
- ☐ ☐ Heat intolerance
- ☐ ☐ Increased thirst

Other:____

Neurological: ALL NEGATIVE

Neg Pos
- ☐ ☐ Difficulty falling asleep
- ☐ ☐ Difficulty staying asleep
- ☐ ☐ Excessive daytime sleepiness
- ☐ ☐ Non-restorative sleep
- ☐ ☐ Numbness in extremities
- ☐ ☐ Fainting spells
- ☐ ☐ Tingling
- ☐ ☐ Tremors
- ☐ ☐ Weakness

Other:____

Psychiatric: ALL NEGATIVE

Neg Pos
- ☐ ☐ Anxiety
- ☐ ☐ Depression
- ☐ ☐ Hallucinations

Other:____

Pain:

Neg Pos
- ☐ ☐ Are you in pain? If yes, location:________________

Pain Scale: 0 1 2 3 4 5 6 7 8 9 10

Turn over- form on back

Vaccine:	Yes	No	Unknown	Date of vaccine:
Flu	☐	☐	☐	____________________
Tetanus	☐	☐	☐	____________________

FAMILY HISTORY - Check illnesses immediate family members have had:

Yes	No		Yes	No	
☐	☐	Asthma	☐	☐	Hearing loss
☐	☐	Allergies	☐	☐	Heart Disease
☐	☐	Bleeding problems	☐	☐	High blood pressure
☐	☐	Cancer; if yes, type:__________________________	☐	☐	Sickle Cell Anemia
☐	☐	Diabetes; if yes, type:_________________________	☐	☐	Thyroid Problems
☐	☐	Glaucoma	☐	☐	Tuberculosis

PATIENT MEDICAL HISTORY – please check and describe any **past problems** in these areas

Yes No

☐ ☐ **Eyes:** ____
(Example: glaucoma, cataracts, vision loss etc)

☐ ☐ **Ears, Nose, Throat:**____
(Example: hearing loss, nose bleeds, sinus disease etc)

☐ ☐ **Nervous System:** ____
(Example: strokes, seizures, etc)

☐ ☐ **Respiratory:**____
(Example: COPD, Asthma, Emphysema, Sleep Apnea etc)

☐ ☐ **Heart:** ____
(Example: arrhythmia, atrial fibrillation, coronary artery disease, congestive heart failure, **hypertension** etc)

☐ ☐ **Abdomen:**____
(Example: Crohn's, hepatitis, GERD, etc)

☐ ☐ **Genital-Urinary System:** ____
(Example: urinary tract infections, kidney stones, etc)

☐ ☐ **Extremities:** ____
(Example: arthritis, gout, etc)

☐ ☐ **Infectious Diseases:**____
(Example: Tuberculosis, HIV, Staph etc)

☐ ☐ **Endocrine:** ____
(Example: Diabetes, thyroid problems etc)

☐ ☐ **Hematology:**____
(Example: anemia, bleeding tendencies etc)

☐ ☐ **Cancer, if yes, type/date:** ____
☐ Chemotherapy/date:______________________
☐ Radiation/date: __________________________

☐ ☐ **Other Medical History:** ____

LIST SURGERIES WITH AGE/DATE:

____
____
____
____

Lifestyle History:	**Yes**	**No**
Do you use alcohol more than 4 times/week?	___	___
Do you use tobacco? Type: ______________	___	___
Do you ever use recreational drugs?	___	___
Do you feel safe in your environment?	___	___

Please circle to indicate the following? **METAL IN BODY** **HEART STENTS** **CURRENTLY ON OXYGEN**

Patient signature:____ Date: ___________________