

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ M.I.: \_\_\_\_\_ Age: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Sports: \_\_\_\_\_

Cardiologist: \_\_\_\_\_

Reason for Appointment: \_\_\_\_\_

**Injuries: Have you ever had in the past?**  
 Broken Bones/Fractures  Yes  No  
 Knee Injuries  Yes  No  
 Sprains or Joint Dislocations  Yes  No  
 Extensive Lacerations  Yes  No  
 Concussion/Head Injury  Yes  No

**Habits: Do you?**  
 Sleep Well  Yes  No  
 Use Alcoholic Beverages  Yes  No  
 Everyday  Yes  No  
 Smoke  Yes  No  
 How Much \_\_\_\_\_ Pks

**Hospitalizations:**  
**Previous Surgical Procedures:**  
 1) \_\_\_\_\_  
 2) \_\_\_\_\_  
 3) \_\_\_\_\_

**Previous Hospitalizations/Illness:**  
 1) \_\_\_\_\_  
 2) \_\_\_\_\_  
 3) \_\_\_\_\_

**Illness: Have you ever had in the past or presently have?**  
 Migraine Headaches  Yes  No  
 Hepatitis  Yes  No  
 Urine Infection  Yes  No  
 Venereal Disease  Yes  No  
 Arthritis  Yes  No  
 Asthma  Yes  No  
 Angina/Heart Problems  Yes  No  
 Rheumatic Fever  Yes  No  
 Frequent infections  Yes  No

Ulcers  Yes  No  
 Gallbladder Disease  Yes  No  
 Seizures/Convulsions  Yes  No  
 Meningitis or Polio  Yes  No  
 Pneumonia  Yes  No  
 Tuberculosis  Yes  No  
 Thyroid Disease  Yes  No  
 High Blood Pressure  Yes  No  
 Diabetes  Yes  No  
 Other Major Disease  Yes  No

**Allergies:**  
 Are you allergic to any medications?  Yes  No

Explain: \_\_\_\_\_  
 What? \_\_\_\_\_

**Medications: List any medications and dosage that you are taking**  
 1) \_\_\_\_\_  
 2) \_\_\_\_\_

3) \_\_\_\_\_  
 4) \_\_\_\_\_

**Family History: Has any blood relative ever had: (Indicate M-Mother, F-Father, B-Brother, S-Sister)**  
 \_\_\_\_\_ Cancer \_\_\_\_\_ Tuberculosis \_\_\_\_\_ Diabetes \_\_\_\_\_ Heart Trouble \_\_\_\_\_ High Blood Pressure  
 \_\_\_\_\_ Epilepsy \_\_\_\_\_ Suicide \_\_\_\_\_ Mental Illness \_\_\_\_\_ Birth Defects \_\_\_\_\_ Alcoholism \_\_\_\_\_ Stroke

Please Check if you Now have or have Recently had any of the following symptoms:  
 **General:** fever, unexplained weight loss, night sweats, unusual fatigue  
 **Neurological:** headaches, paralysis, numbness, speech problems, double vision, blurred vision, fainting, falling  
 **Eyes:** blindness, cataract, glaucoma, sudden loss of vision in one eye  
 **Ears:** decreased hearing, infection, dizziness, vertigo  
 **Throat:** swallowing difficulty, pain with chewing  
 **Heart:** chest pain, palpitations  
 **Lungs:** shortness of breath, persistent cough, blood in sputum  
 **G-I:** diarrhea, constipation, nausea, vomiting, bloody or tarry black stools  
 **Hematologic:** unusual bleeding, easy bleeding  
 **G-U:** difficulty urination with, hesitancy, urgency, burning, incontinence  
 **Psychiatric:** depression, severe anxiety, hallucinations  
 **Skin:** rash, skin cancer  
 **Musculoskeletal:** joint pain, swelling, locking, catching, buckling, giving away, redness, warmth, stiffness, muscle cramps, night pain (waking from sleep)

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_