Name:_____ **Date of Birth:**_____

Past Medical History

Have you ever had the following (please circle):

Heart Attack	Y / N	Diabetes	Y / N	COPD	Y / N
High blood pressure	Y / N	Kidney disease	Y / N	Asthma	Y / N
High cholesterol	Y / N	Thyroid disease	Y / N	Sleep Apnea	Y / N
Irregular heartbeat	Y / N	AIDS/HIV	Y / N	Cataracts	Y / N
Acid Reflux	Y / N	Tuberculosis	Y / N	Glaucoma	Y / N
Stomach ulcer	Y / N	Hepatitis	Y / N	Macular degeneration	Y / N
Prostate disease	Y / N	Arthritis	Y / N	Stroke	Y / N
Seasonal allergies	Y / N	Rheumatoid arthritis	Y / N	Migraine	Y / N
Sjogren's	Y / N	Osteoarthritis	Y / N	Depression	Y / N
Multiple Sclerosis	Y / N	Lupus	Y / N	Anxiety	Y / N

Please list any other medical problems/illness:

_____

_____

_____

_____

Past Surgical History

Please list any previous surgeries and the procedure date:

Surgery	Date	Surgery	Date

Review of Systems

Are you currently experiencing any of the following problems:

Hearing Loss	Y / N	Dizziness	Y / N	Arthritis	Y / N
Sinus problems	Y / N	Headache	Y / N	Joint swelling	Y / N
		Numbness	Y / N	Muscle weakness	Y / N
Asthma	Y / N	Difficulty walking	Y / N		
Cough	Y / N			Environmental Allergies	Y / N
Wheezing	Y / N	Depression	Y / N	Food Allergies	Y / N
		Irritability changes	Y / N		

Social History

Tobacco Use: Y / N Type: _____ Age Quit: _____

Alcohol Use: Y / N Amount: _____

Continue on other side ⟶

Medication List

Medication Name	Dose *(milligrams)*	Schedule *(how often)*

Drug Allergies

Continue on other side ⟶