

Name \_\_\_\_\_ DOB \_\_\_\_\_ Date \_\_\_\_\_

Please note any changes since your last visit of \_\_\_\_\_ .

Phone numbers:

Home \_\_\_\_\_

Work \_\_\_\_\_

Employment

\_\_\_\_\_

Primary Care Doctor:

\_\_\_\_\_

Surgeries/Major Illness:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medications:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Herbal and Supplemental Medications:

\_\_\_\_\_  
\_\_\_\_\_

Symptoms: (circle any that you are experiencing)

CONST – fever, chills, fatigue, weight loss, poor appetite

ENT – sore throat, runny nose, earache

EYES – blurry vision, spots

CV – chest pain, irregular heartbeat

RESP – shortness of breath, persistent cough, wheezing

GI – nausea, vomiting, diarrhea, constipation, blood, black tarry stools, other changes in bowel movements, abdominal pain

GU -urinary – trouble urinating, burning, pain, blood, change in frequency, urgency, leakage, other

GYN – bleeding between periods, bleeding with intercourse, heavy or long periods, cramps, vaginal discharge, itching or irritation, pain with intercourse.

BREAST – lumps, discharge, skin changes

ENDO – hot flashes, vaginal dryness, intolerance to heat or cold

MS – pain, weakness, joint problems

NEURO – headaches, seizures, numbness or tingling

PSYCH – depression, anxiety

ALLERGY – sneezing, itchy eyes

SKIN – itching, dry, rash, moles that have changed

Changes in family history (cancer, deaths, major illnesses)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_