WELCOME

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(Please print, fill out and bring completed forms to your first appointment.)

NAME: ____

ADDRESS: ____
____
____

PHONE: ____________________________(home)
____________________________(work)
____________________________(cell/beeper)

E-MAIL ADDRESS: ____

(Please specify if any discretion is necessary in contacting these numbers to remind you about appointments, etc.)

____

PHYSICIAN: ____

Whom may I thank for referring you to me?

____

MEDICATIONS/SUPPLEMENTS	DOSE	FREQ

IILLNESSES/CONDITIONS/INJURIES/SURGERIES (Current or past)

____
____
____
____
____
____

ALLERGIES: ____
____

Name____ (Check appropriate boxes and fill in blanks.)

HEAD and NECK
- ☐ Frequent headaches
- ☐ Neck pain
- ☐ Neck lumps or swellings

EYES
- ☐ Wear glasses
- ☐ Eyesight worsening
- ☐ Blurry vision
- ☐ "Floaters"
- ☐ Double vision
- ☐ Halos
- ☐ Eye pain or itching
- ☐ Watery eyes

EARS
- ☐ Hearing difficulties
- ☐ Earaches
- ☐ Drainage from ears
- ☐ Ringing in ears
- ☐ Motion sickness

MOUTH
- ☐ Dental problems
- ☐ Swelling in gums or jaws
- ☐ Sores on tongue or mouth
- ☐ Taste changes

NOSE and THROAT
- ☐ Congested nose
- ☐ Running nose
- ☐ Sneezing spells
- ☐ Frequent headcolds
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Enlarged tonsils
- ☐ Hoarse voice

RESPIRATORY
- ☐ Wheezing or gasping
- ☐ Coughing spells
- ☐ Excessive phlegm
- ☐ Have coughed up blood
- ☐ Chest colds/bronchitis
- ☐ More sweating/night sweats

CARDIOVASCULAR
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Racing heart beat
- ☐ Slow heart beat
- ☐ Irregular heart beat
- ☐ Heart murmur
- ☐ Shortness of breath
- ☐ Need to sit up to breathe
- ☐ Swollen feet or ankles
- ☐ Cold extremities
- ☐ Leg cramps

DIGESTIVE
- ☐ Heartburn
- ☐ Bloated abdomen
- ☐ Abdominal pain
- ☐ Nausea and/or vomiting
- ☐ Vomiting blood
- ☐ Difficulty swallowing
- ☐ Belching/hiccoughs
- ☐ Constipation
- ☐ Loose bowels
- ☐ Pain in rectum
- ☐ Rectal bleeding/black stools

URINARY
- ☐ Night frequency
- ☐ Day frequency
- ☐ Leaking urine
- ☐ Burning on urination
- ☐ Discolored/cloudy urine
- ☐ Urgency

MALE GENITAL
- ☐ Weak urine stream
- ☐ Difficulty initiating urination
- ☐ Burning or discharge
- ☐ Lumps on testicle(s)
- ☐ Painful testicle(s)
- ☐ Erectile difficulties

FEMALE GENITAL
- ☐ Date of last period_________
- ☐ Menopausal or hysterectomy
- ☐ Heavy periods
- ☐ Pass clots with periods
- ☐ Cramps
- ☐ Bleeding between periods
- ☐ Irregular periods
- ☐ Recent vaginal itch/discharge
- ☐ Lump or pain in breast

OBSTETRIC HISTORY
- ____ Number of pregnancies
- ____ Number of live births
- ____ Number of pre-term births
- ____ Number of miscarriages
- ____ Number of stillbirths
- ____ Abortion(s)
- ☐ Difficulty conceiving

MUSCULOSKELETAL
- ☐ Aching muscles or joints
- ☐ Swollen joints
- ☐ Low back pain
- ☐ Upper back or shoulder pain
- ☐ Knee pain
- ☐ Elbow pain
- ☐ Pain in feet or hands

SKIN
- ☐ Itching or burning skin
- ☐ Bruise easily
- ☐ Acne
- ☐ Eczema
- ☐ Other skin problems

NEUROLOGICAL
- ☐ Seizures
- ☐ Change in handwriting
- ☐ Tremor
- ☐ Numbness
- ☐ Balance problems

MOOD
- ☐ Nervous with strangers
- ☐ Difficulty making decisions
- ☐ Lack of concentration
- ☐ Memory difficulties
- ☐ Lonely or depressed
- ☐ Frequent crying
- ☐ Hopeless outlook
- ☐ Suicidal thoughts/plan
- ☐ Difficulty relaxing
- ☐ Worry
- ☐ Fearful thoughts/dreams
- ☐ Shy or sensitive
- ☐ Volatile temper
- ☐ Irritated by small things
- ☐ Work or family problems
- ☐ Loss of libido
- ☐ Insomnia or excessive sleep
- ☐ Receiving psychiatric help

GENERAL
- ☐ Gained 10 lbs or more in year
- ☐ Lost 10 lbs or more in year
- ☐ Tendency to feel hot
- ☐ Tendency to feel cold
- ☐ Always hungry
- ☐ More thirsty lately
- ☐ Exhausted or fatigued
- ☐ Swelling in groin/armpits
- ____ # of glasses of water daily
- ____ # of cups of coffees daily
- ____ # of alcoholic drinks daily
- ____ # cigarettes daily
- ____ # of years smoked
- ☐ Marijuana use

(If checked, amount?_________)

- ☐ Other drug use

(If checked, what and how much?)

____

_________ Miles driven per year

- ☐ Wear seatbelts

Date of last physical exam______

Special problems or symptoms: ____