

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
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_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

ILLNESSES/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
- Bloating 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: _____