

When was your last physical/medical exam? _____ Who was your physician? _____

List all medications you take (including prescription and non-prescription medications, birth control pills, eye drops, vitamins and herbal supplements/home remedies): _____

List all major injuries, surgeries &/or hospitalizations: _____

List any known allergies to medications and the type of reaction you had: _____

Do you currently, or have you ever had, any problems in the following areas:

System	Yes	No	If yes, please explain
<u>Allergic/Immune System Disorder</u> hay fever, allergies			
<u>Bones/Joints/Muscles</u> rheumatoid arthritis, muscle/joint pain, swollen joints			
<u>Cardiovascular</u> chest pain, heart problems, high blood pressure, high cholesterol, circulatory or vascular disease, stroke			
<u>Constitutional</u> fever, unexplained weight change, fatigue, other			
<u>Ear, Nose and Throat</u> sinus congestion, runny nose, chronic cough, dry mouth			
<u>Endocrine</u> diabetes, thyroid, other glands, neck pain			
<u>Gastrointestinal</u> heartburn, acid reflux, abdominal pain, recurrent diarrhea			
<u>Genitourinary</u> genitals, kidney or bladder problems			
<u>Integumentary (Skin)</u> rashes, excessive dryness, itching			
<u>Lymphatic/Hematologic</u> anemia, blood disorders, bleeding problems			
<u>Nervous System</u> headaches, numbness, weakness, paralysis, dizziness, motion sickness, seizures, multiple sclerosis			
<u>Psychiatric/Emotional/Mental</u> anxiety, depression, ADHD, special needs			
<u>Respiratory</u> shortness of breath, wheezing, coughing, asthma, chronic bronchitis, emphysema			
<u>Other</u> cancer, other conditions not listed			

Does, or did, anyone in your immediate family have any of the following? If no conditions apply, check here:

<input type="checkbox"/> Diabetes	Who: _____	<input type="checkbox"/> Arthritis	Who: _____
<input type="checkbox"/> High Blood Pressure	Who: _____	<input type="checkbox"/> Migraines	Who: _____
<input type="checkbox"/> Thyroid Disorder	Who: _____	<input type="checkbox"/> Cancer	Who: _____

This information is kept strictly confidential. Do you: Use tobacco Drink alcohol Use recreational/illicit drugs None

If yes, please give the type, frequency, amount, and duration (how long): _____

Have you ever been exposed to or infected with: Gonorrhea Hepatitis HIV Syphilis

Patient (or parent) signature: _____ Date: _____

Doctor's Initials: _____ Date: _____