HISTORY SUMMARY

Today's Date: _____

Patient Name _____DOB_____ Age _____
Home Phone _____ Cell Phone _____ Email _____
Pharmacy Name: _____ Pharmacy telephone #: _____
Primary Doctor _____ Referring Doctor _____
Height _____ Current Weight _____ Marital Status _____
Occupation: _____ Employer: _____

Reason for Today's Visit _____
_____
_____
When did it begin?_____ Symptoms:_____
_____

Current Medications & Dosages: _____
_____

Allergies: _____

Previous Surgeries

_____
_____
_____
_____
_____

Do You Smoke? ___Yes ___No Quit: _____
How Much? _____ # of Years_____
Recreational Drug use: ___yes ___no
Alcohol intake? ___yes ___no How much? _____

Medical History

____Diabetes
____High Blood Pressure
____High Cholesterol
____Heart Disease
____Hearing Problems
____Thyroid Disease
____Cancer (type) _____
____Migraines
____COPD _____Asthma
_____ Snoring
_____ Sleep Apnea
_____ Hepatitis
_____ Kidney Disease
_____ Colon/intestinal Problems
_____ Autoimmune Disease
_____ Anesthesia Problems
_____ Bleeding Disorders
Other - specify _____

Family History

_____ Hearing Loss
_____ Thyroid Cancer
_____ Malignant Hyperthermia
_____ Bleeding Disorders
_____ Other family history, specify
_____
_____
_____

Review of Systems

Constitutional
____Fever
____Fatigue

Respiratory
_____Chronic Cough
_____Shortness of Breath

Neurological
_____Tremors/hand shaking
_____Seizures
_____Stroke

Eyes
____Dry Eyes
____Poor Vision

Musculoskeletal
_____Joint Pain
_____Muscle Pain

Psychiatric
_____Anxiety
_____Depression

Cardiovascular
____Angina (chest Pain)
____Arrhythmias/Afib

Genitourinary
_____Prostate Hypertrophy
_____ED

Allergic/Immunologic
_____Food Allergies
_____Eczema

ENT/mouth
____Facial Fractures
____Nose Bleeds

Endocrine
_____Hormone Therapy
_____Weight gain/loss

Hematologic/lymphatic
_____Easy bleeding/bruising
_____DVT/Blood Clots/Pulmonary embolism

GI
____Heartburn/GERD

Other Medical Problems: _____
_____

Patient Signature _____ **DO/MD Signature** _____