

ALLERGIES		
Check if you are allergic to : <input type="checkbox"/> Latex <input type="checkbox"/> IV Dye <input type="checkbox"/> Iodine/Betadine <input type="checkbox"/> Tape <input type="checkbox"/> Sulfa <input type="checkbox"/> Steroids		
<input type="checkbox"/> No known drug allergies		
<i>Please list any other medications you are allergic to:</i>		
MEDICATIONS		
<i>Please list all medications you are currently taking, including dosage and frequency (include insulin and blood thinners):</i>		
Medication	Dosage	Frequency
PAST MEDICAL HISTORY		
<i>Check if you have or had:</i>		
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Stomach/GI ulcers	<input type="checkbox"/> Sleep Apnea (CPAP/BiPAP/O ₂)
<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Kidney Disease	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Dialysis	<input type="checkbox"/> Bleeding Problems
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Hiatal Hernia	<input type="checkbox"/> Blood Transfusion
<input type="checkbox"/> Heart Rhythm Disorder	<input type="checkbox"/> Gastric Reflux	<input type="checkbox"/> Blood Clots
<input type="checkbox"/> Heart Failure	<input type="checkbox"/> Cancer: _____	<input type="checkbox"/> Depression
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other Mental Disorders
<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Gout	<input type="checkbox"/> Substance Abuse
<input type="checkbox"/> Pacemaker	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Addiction
<input type="checkbox"/> Stroke	<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Sexually Transmitted Disease
<input type="checkbox"/> Diabetes (diet / pills / insulin)	<input type="checkbox"/> Asthma	<input type="checkbox"/> Chronic Infection (i.e. MRSA)
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> RSV	<input type="checkbox"/> Possibility of Pregnancy
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> COPD	<input type="checkbox"/> OTHER:
PAST SURGICAL HISTORY		
<i>Please list all surgeries you've had in the past performed:</i>		
Type of Surgery	Date	Surgeon
FAMILY HISTORY		
<i>Please check immediate family history conditions:</i>		
Member	Age At Death	Cause of Death
Mother		
Father		
Siblings		
Grandparents		

REVIEW OF SYSTEMS		
<i>Check if you currently have the following:</i>		
<input type="checkbox"/> Recent Weight change	<input type="checkbox"/> Vision Change	<input type="checkbox"/> Numbness
<input type="checkbox"/> Chills	<input type="checkbox"/> Eye Pain	<input type="checkbox"/> Tingling
<input type="checkbox"/> Fever	<input type="checkbox"/> Double Vision	<input type="checkbox"/> Loss of sensation in any area
<input type="checkbox"/> Excessive Thirst	<input type="checkbox"/> Abdominal Pain	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Hot/Cold Intolerance	<input type="checkbox"/> Nausea/Vomiting	<input type="checkbox"/> Headaches
<input type="checkbox"/> Excessive Fatigue	<input type="checkbox"/> Heartburn	<input type="checkbox"/> Swelling of joints (overall)
<input type="checkbox"/> Chest Pain	<input type="checkbox"/> Rash	<input type="checkbox"/> Muscle Aches
<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Persistent Itch	<input type="checkbox"/> Neck Pain
<input type="checkbox"/> Palpitations	<input type="checkbox"/> Abnormal Scars	<input type="checkbox"/> Back Pain
<input type="checkbox"/> Swelling in Legs	<input type="checkbox"/> Skin Infections	<input type="checkbox"/> Wheezing
<input type="checkbox"/> Fainting	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Frequent Cough
<input type="checkbox"/> Loss of hearing	<input type="checkbox"/> Swollen Glands	<input type="checkbox"/> Painful Urination
<input type="checkbox"/> Ear Infection	<input type="checkbox"/> Depression	<input type="checkbox"/> Urinary Frequency
<input type="checkbox"/> Sore Throat	<input type="checkbox"/> Ever Considered Suicide	<input type="checkbox"/> OTHER:
<input type="checkbox"/> Easy Bruising	<input type="checkbox"/> Addiction	<input type="checkbox"/>
<input type="checkbox"/> Anemia	<input type="checkbox"/> Severe Mood Swings	<input type="checkbox"/>
PATIENT SIGNATURE		
<i>This information is true to the best of my knowledge.</i>		
Patient Name (Print): _____		
Patient / Guardian Signature: _____		
Date: _____		

Physician's Signature: _____ Date: _____

IMPORTANT - Bring previous X-rays, MRI films and radiology report with you to your appointment.