*Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ *SSN:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**Please ✓ all that apply**

*Review of Systems:*

|  |  |
| --- | --- |
|  | DIABETIC |
|  | HIGH BLOOD PRESSURE |
|  | PREGNANT OR NURSING |

*Do you currently experience any symptoms related to the following?*

|  |  |  |  |
| --- | --- | --- | --- |
|  | EAR, NOSE THROAT |  | NEUROLOGICAL |
|  | CARDIOVASCULAR |  | PSYCHIATRIC |
|  | RESPIRATORY |  | ENDOCRINE |
|  | GENITAL, KIDNEY, BLADDER |  | BLOOD/LYMPH |
|  | MUSCLES, BONES, JOINTS |  | GASTROINTESTINAL |
|  | SKIN |  | OTHER: |
|  | ALLERGIC/ IMMUNOLOGIC |  | OTHER: |

|  |  |
| --- | --- |
|  | *Social History:* |
|  | USE TOBACCO PRODUCTS |
|  | DRINK ALCOHOL |
|  | USE ILLEGAL DRUGS |
|  | STD |

|  |  |
| --- | --- |
|  | CURRENTLY TAKING MEDICATIONS OR SUPPLEMENTS |
|  | ALLERGIC TO ANY MEDICATIONS |
|  | MAJOR INJURIES, SURGERIES OR HOSPITALIZATIONS |

|  |
| --- |
| If you are taking medications or supplements, do you have a list with you? |
|

|  |  |  |  |
| --- | --- | --- | --- |
|   | YES |  | NO |

 |

|  |  |  |  |
| --- | --- | --- | --- |
| *Primary Care Physician:* | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* | *Office Location:* | *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_* |
| *Family History:*  | Please *✓* if your mother, father, brother or sister have ever been diagnosed with the following: |

|  |  |  |  |
| --- | --- | --- | --- |
|  | BLINDNESS |  | LUPUS |
|  | MACULAR DEGENERATION |  | CROSSED EYES |
|  | RETINAL DETACHMENT |  | KIDNEY DISEASE |
|  | CATARACTS |  | THYROID DISEASE |
|  | HEART DISEASE |  | ARTHRITIS |
|  | DIABETES |  | CANCER |
|  | HIGH BLOOD PRESSURE |  | OTHER: |

Do you have any other health related concerns that haven’t been mentioned above?

|  |  |  |  |
| --- | --- | --- | --- |
|  | YES |  | NO |

|  |  |  |  |
| --- | --- | --- | --- |
| PATIENT (OR GUARDIAN) SIGNATURE | x\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
|  |  |  |  |