

Name:	Account #:	Date:
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Referring Provider:	Primary Provider:
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Please answer all of the following questions below:

Age:	Date of Birth:	List any Allergies to Medications:	<input type="checkbox"/> NKDA n r sob sh n r sob sh n r sob sh n r sob sh n r sob sh
What problems are you here for today? (chief complaint)		_____ _____ _____ _____	

Past Medical History:

1) Please check the "Yes" or "No" box to indicate if you have any of the following illnesses; for "Yes" answers, please explain

	Yes	No	
Diabetes (sugar problem)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid problems (high / low)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Hypertension (high blood pressure)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Coronary Artery Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart attack (MI) (how many / when)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Valve Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Congestive Heart Failure (CHF)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mitral Valve Prolapse (MVP)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stroke (CVA) (how many / when)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Mini-Stroke (TIA) (how many / when)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches (Migraines / other)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Seizure Disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Multiple Sclerosis (MS)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Neurologic Problem (Parkinsons)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Cancer (type / year diagnosed)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Melanoma / Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Bleeding Problem	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma (stable or unstable)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lung Problem (COPD, Black lung, etc)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Acid Reflux (GERD) (Barrett's Esoph)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach Ulcers (PUD) (bleeding?)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Intestinal Problem (Crohn's/Ulcerative)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Autoimmune Disease (Lupus / Sjogren's)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Immune Deficiency (HIV / Transplant)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Environmental Allergies (tested / shots)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Enlarged Prostate / Urinary Problems	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidney Failure (on Dialysis?)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eye Problems (Glaucoma / Cataracts)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Sleep Apnea (OSA) (use CPAP / BIPAP)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychiatric Problems (Anxiety / Depress)	<input type="checkbox"/>	<input type="checkbox"/>	_____
Other Medical Problems:			_____

_____ _____	Reviewed by:
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Review of Systems: Please indicate whether you presently have any of the following symptoms. If “yes” please indicate if your primary care physician (PCP) is aware:

		Yes	No	PCP is aware			Yes	No	PCP is aware			Yes	No	PCP is aware
GENERAL	fever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	chills	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	night sweats	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	fatigue	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weight loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	weight gain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
EYES	dryness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	itching	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	excessive tearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	impaired vision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	peripheral vision changes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
ENT	nasal pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	nose bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	smell decreased	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	itchy nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nasal congestion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	runny nose	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	throat pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	postnasal drip	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	frequent throat clearing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	lump in throat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hoarseness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	snoring	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	mouth breathing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	dry mouth	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	bad breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	tongue burning	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	mouth pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	oral sores	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	mouth swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	decreased sense of taste	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	drooling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	ear pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	itching ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	pressure sensation ear	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	ear drainage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hearing loss	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	spinning sensations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	roaring sounds in ears	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	pulsatile tinnitus	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	neck pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck swelling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	neck mass	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	CARDIAC	chest pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	palpitations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>					
RESPIR	shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	wheezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cough	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
GI	difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	painful swallowing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	heartburn	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	regurgitation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	nausea	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	vomiting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
GU	difficulty urinating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	frequent urinating	<input type="checkbox"/>	<input type="checkbox"/>							
SKIN	new skin lesions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	rash	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
NEURO	headaches	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	daytime sleepiness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	tingling or numbness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	speech difficulties	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	light headedness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loss of balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	difficulty walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
MSK	jaw pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	grind teeth (bruxism)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	joint pain	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
ENDO	heat intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	cold intolerance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	loss of hair	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		
	excessive sweating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>										
PSYCH	anxiety	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	depression	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
HEM/LYM	easy bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	lymph node enlargement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>						
ALLERGY	hives	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	itchy skin	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	sinus allergy symptoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>		