

NAME _____ DATE _____ AGE _____ DOB _____

REASON FOR VISIT _____

HAVE YOU HAD IN THE PAST:

DIABETES..... YES NO
HEART TROUBLE..... YES NO
HIGH BLOOD PRESSURE.. YES NO
ASTHMA..... YES NO
LUNG TROUBLE..... YES NO
EPILEPSY..... YES NO
KIDNEY DISEASE..... YES NO
JAUNDICE..... YES NO
BLEEDING TENDENCIES.. YES NO
OTHER ILLNESS..... YES NO
EXPOSURE TO INFECTIOUS
DISEASE (HIV, HEPATITIS,
TB, ETC.)..... YES NO
PLEASE LIST: _____

ANY FAMILY HISTORY OF
DISEASE (HIGH BP, HEART,
DIABETES, CANCER, ETC.) YES NO
PLEASE LIST: _____

BLOOD TRANSFUSION..... YES NO
ALLERGIES TO MEDICATION. YES NO
PLEASE LIST: _____

DO YOU:

TAKE DRUGS OR MEDICATION
INCLUDING ASPIRIN..... YES NO
PLEASE LIST: _____

SMOKE..... YES NO
DRINK ALCOHOL..... YES NO
OBJECT TO A TRANSFUSION YES NO

HAVE YOU HAD:

PREVIOUS SURGERY, PLEASE LIST
TYPE AND DATES: _____

PREVIOUS INJURIES, PLEASE LIST
INJURY AND DATE: _____

ARE YOU PREGNANT YES NO
LAST MENSTRUAL PERIOD: _____
PULSE: _____ BP: _____
HT: _____ WT: _____

ARE YOU CURRENTLY EXPERIENCING:

EARS: RECURRING EAR INFECTIONS,
HEARING LOSS..... YES NO

EYES: VISUAL PROBLEMS, DRY EYES... YES NO

THROAT: SORES IN MOUTH OR THROAT,
HOARSENESS, DIFFICULTY IN
SWALLOWING, LUMP IN NECK YES NO

NOSE: DIFFICULTY BREATHING
THROUGH NOSE, BROKEN NOSE,
ALLERGIES..... YES NO

HEART: CHEST PAIN, IRREGULAR
HEARTBEAT..... YES NO

BREAST: LUMPS, PAIN, DISCHARGE..... YES NO

ABDOMEN: ABDOMINAL PAIN, HEARTBURN
CONSTIPATION, DIARRHEA,
BLOOD IN STOOL..... YES NO

EXTREMITIES: ARTHRITIS, JOINT
PROBLEMS, BROKEN BONES
UNUSUAL PAIN..... YES NO

LUNGS: PNEUMONIA, COUGH, WHEEZING YES NO

NEURO: EPILEPSY, HEADACHES, WEAKNESS
OR NUMBNESS, DIZZINESS..... YES NO

GU-GYN: URINARY PROBLEMS, PROSTATE
UTERUS, OVARIES..... YES NO

HEENT:
ABDOMEN:
LUNGS:
HEART:
BREASTS:
EXTREMITIES:
