

NAME: \_\_\_\_\_

DATE: \_\_\_\_\_

**Please CLEARLY print ALL of your current medications and doses**

Medication	Dose	Frequency	Reason for Medication

**Please CLEARLY print ALL past medical conditions and surgeries**


**Please CLEARLY print ALL allergies and reactions**

Allergy	Reaction

**Review of Systems (Circle all that pertain to you):**

- |                       |                     |                   |                 |
|-----------------------|---------------------|-------------------|-----------------|
| Fever                 | Recent Weight Loss  | Seizure           | Fainting Spells |
| Difficulty Swallowing | Shortness of Breath | Abnormal Bleeding | Chest Pain      |

**Past Medical History (Circle all that pertain to you):**

- |                          |                   |                |
|--------------------------|-------------------|----------------|
| CONGESTIVE HEART FAILURE | BLEEDING DISORDER | FIBROMYALGIA   |
| EMPHYSEMA                | HIGH CHOLESTEROL  | THYROID        |
| HIGH BLOOD PRESSURE      | BLOOD CLOTS       | STOMACH ULCERS |
| DIABETES                 | ANXIETY           | STROKE         |
| CANCER                   | DEPRESSION        | BIPOLAR        |

**Family History (Check all that pertain to you):**

- Cancer
  Coronary Artery Disease
  Stroke
  None

**Social History:**

- SMOKING:  Yes  No  Previous  
 ALCOHOL USE:  Never  Daily  Occasionally  Previous  
 RECREATIONAL DRUGS:  Yes  No  Previous