



## PATIENT MEDICAL FORM

ARE YOU CURRENTLY EXPERIENCING ANY OF THE FOLLOWING SYMPTOMS? PLEASE CHECK ALL THAT APPLY.

### CONSTITUTIONAL SYMPTOMS

- FEVER
- NIGHT SWEATS
- UNEXPLAINED WEIGHT LOSS

### EYES, EARS, NOSE, MOUTH, THROAT

- COLD
- HEARING LOSS
- LOSS OF VISION
- RUNNY NOSE
- SORE THROAT
- VISION CHANGES

### ENDOCRINE

- DIABETES
- HIGH CHOLESTEROL
- THYROID PROBLEMS

### INTEGUMENTARY

- BLEEDING MOLES
- CHANGING MOLES
- RASHES
- SKIN CHANGES

### MUSCULOSKELETAL

- ARTHRITIS
- BACK PAIN
- FOOT SORES
- PAIN IN FEET OR CALVES

### ALLERGIC & IMMUNOLOGIC

- ALLERGIES

### NEUROLOGICAL

- DIZZINESS
- HEADACHES
- PASSING OUT
- SEIZURES
- STROKE
- WEAKNESS/NUMBNESS IN ARMS/LEGS

### HEMATOLOGICAL & LYMPHATIC

- BLEEDING OR BRUISING
- HIV
- HAVE YOU EVER HAD A BLOOD TRANSFUSION? \_\_\_\_\_

### CARDIOVASCULAR & RESPIRATORY

- ANKLE SWELLING
- CHEST PAIN
- COUGH
- HEART ATTACK
- HIGH BLOOD PRESSURE
- PALPITATIONS
- SHORTNESS OF BREATH
- WHEEZING

### GASTROINTESTINAL

- ABDOMINAL PAIN
- BLOOD IN STOOL
- DIARRHEA
- HEPATITIS-B
- HEPATITIS-C
- NAUSEA/VOMITING

<b>HAVE YOU EVER SMOKED?</b> IF YES: HOW LONG?_____ HOW MANY YEARS?_____	<b>Y</b>	<b>N</b>
<b>HAVE YOU QUIT SMOKING?</b> IF SO: WHEN_____	<b>Y</b>	<b>N</b>
<b>DO YOU DRINK ALCOHOLIC BEVERAGES? IF SO: HOW MANY PER WEEK?_____</b>	<b>Y</b>	<b>N</b>
<b>HAVE YOU EVER HAD CANCER?</b> IF SO: WHAT KIND? _____	<b>Y</b>	<b>N</b>
<b>FEMALES: ARE YOU CURRENTLY PREGNANT? OR LACTATING?</b>	<b>Y</b>	<b>N</b>
<b>HAVE YOU HAD A BREAST EXAM?</b>	<b>Y</b>	<b>N</b>
<b>HAVE YOU HAD A MAMMOGRAM?</b>	<b>Y</b>	<b>N</b>
<b>HAVE YOU HAD PAP TEST TO SCREEN FOR CERVICAL CANCER?</b>	<b>Y</b>	<b>N</b>
<b>HAVE YOU HAD A PROSTATE EXAM?</b>	<b>Y</b>	<b>N</b>
<b>HAVE YOU HAD A PSA TEST?</b>	<b>Y</b>	<b>N</b>

PLEASE LIST ANY OPERATIONS:\_\_\_\_\_

\_\_\_\_\_

ANY OTHER MEDICAL PROBLEMS NOT LISTED?

\_\_\_\_\_

LIST CURRENT MEDICATIONS:

\_\_\_\_\_

\_\_\_\_\_

ALLERGIES\_\_\_\_\_ LATEX? Y N ADHESIVE TAPES? Y N

**FAMILY HISTORY:**

DO ANY OF THESE RUN IN YOUR FAMILY?

- BLEEDING DISORDERS
- KIDNEY DISEASE
- VASCULAR DISEASE
- HIGH BLOOD PRESSURE
- HEART DISEASE
- DIABETES
- STROKE
- HISTORY OF CANCER? IF YES: WHAT  
KIND?\_\_\_\_\_