

Patient Name _____

Please Circle No or Yes:

ALLERGIES

Known food allergiesNo Yes
 LatexNo Yes
 SeasonalNo Yes

CARDIOVASCULAR

Heart attack (MI).....No Yes
 Chest pain.....No Yes
 Valve disease.....No Yes
 Arrhythmia/palpitationsNo Yes
 High blood pressureNo Yes
 History of Blood Clots (DVT).....No Yes

CONSTITUTIONAL

FeverNo Yes
 HeadachesNo Yes

ENDOCRINE

Thyroid diseaseNo Yes
 Renal/Kidney disease.....No Yes
 Diabetes.....No Yes

EYES

Eye disease or injuryNo Yes
 Wear glasses/contact lens.....No Yes
 Blurred or double visionNo Yes

GASTROINTESTINAL

EsophagitisNo Yes
 GastritisNo Yes
 UlcersNo Yes
 Reflux diseaseNo Yes
 Nausea or vomiting.....No Yes
 Blood in stool.....No Yes
 Liver diseaseNo Yes

GENITOURINARY

Frequent urination.....No Yes
 Burning or painful urinationNo Yes
 Blood in urineNo Yes
 Incontinence or dribbling.....No Yes

HEMATOLOGIC/LYMPHATIC

Easily bruise or bleed.....No Yes
 Anemia.....No Yes
 Hepatitis A, B, C.....No Yes
 HIV or exposure to.....No Yes

NEUROLOGICAL

Convulsions or seizuresNo Yes
 StrokeNo Yes

PULMONARY/RESPIRATORY

Frequent coughingNo Yes
 Spitting up blood.....No Yes
 Shortness of breath.....No Yes
 Asthma or wheezingNo Yes
 Sleep apneaNo Yes
 COPD.....No Yes

SKIN

History of PsoriasisNo Yes
 Rash or itchingNo Yes
 Change in moles or skin lesions.....No Yes
 Vericose veinsNo Yes

Patient Signature _____

Date _____

Practioner Initials/Date _____