

Patient Medical Information Sheet

Name: _____ Birthdate: _____ Date: _____

What problem brought you to see us today? _____

What medical problems do you currently have that you have seen a physician for? _____

List your current medications prescribed by a doctor (include dosage amount and frequency) _____

List all vitamins or herbal supplements you currently take: _____

List all known medication allergies and the reaction it causes: _____

Please list **all** previous surgeries and approximate dates: _____

Are you pregnant? (Females only) Yes No Date of last menstrual period _____

How many pregnancies have you had? _____

Please check box if you currently have or recently had....

- | | | | |
|--|--|--|--|
| <input type="checkbox"/> Fevers | <input type="checkbox"/> Shaking / Chills | <input type="checkbox"/> Weight Loss | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Blurry Vision | <input type="checkbox"/> Double Vision | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Sore Throat |
| <input type="checkbox"/> Chest pains | <input type="checkbox"/> Fluttering of heart | <input type="checkbox"/> Leg / Foot Swelling | <input type="checkbox"/> Coughing Blood |
| <input type="checkbox"/> Shortness of Breath | <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Heart burn |
| <input type="checkbox"/> Blood in stool | <input type="checkbox"/> Black tarry stool | <input type="checkbox"/> Abdominal Pain | <input type="checkbox"/> Leaking urine |
| <input type="checkbox"/> Burning with urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Urge to urinate immediately | <input type="checkbox"/> Bone / Joint Pain |
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Skin sores | <input type="checkbox"/> Bleeding | <input type="checkbox"/> Excessive thirst |
| <input type="checkbox"/> Swelling of Lymph nodes | <input type="checkbox"/> Cold Intolerance | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Weakness |
| <input type="checkbox"/> Easy Bruising | <input type="checkbox"/> Depression | <input type="checkbox"/> Numbness / Tingling | |
| <input type="checkbox"/> Heat Intolerance | <input type="checkbox"/> Seizures | | |
| <input type="checkbox"/> Anxiety | | | |
| <input type="checkbox"/> Fainting | | | |

Do you or have you ever smoked? Yes No

If yes, how much per day and how long? _____ If you have quit, how long ago? _____

Do you drink alcohol? Yes No If yes, how much per week? _____

Do you use street drugs (marijuana, methamphetamines, cocaine, heroin, etc.) Yes No

If yes, please list _____

List family illnesses for parents, siblings, grandparents if known _____

FOR MEDICAL USE ONLY

B/P: _____ Pulse: _____ O2: _____ Temp: _____ Weight: _____ lbs.