

HEALTH SUMMARY

Patient name (please PRINT): _____ Gender: _____ DOB: _____

Employer: _____ Occupation: _____

Referred by: _____ Primary Care Physician: _____

ALLERGIES NONE: _____

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MEDICATIONS NONE: _____

PRESENT HEALTH CONDITIONS

YES	NO	DISEASE	YES	NO	DISEASE
		Irregular Heart Beat			Skin Disease, Type:
		Congestive Heart Failure			Stroke
		Heart Attack			Epilepsy/Seizure
		Heart Murmur			Diabetes/High Blood Sugar
		Rheumatic Fever			Thyroid Problems – too high or too low
		High Cholesterol			Anemia/Low Blood
		High Blood Pressure			Bleeding Problems, Type:
		Asthma			Blood Transfusion
		Emphysema/Chronic Bronchitis			Cancer, Type:
		Blood Clot in Lung			Anxiety
		Blood Clot in Leg			Depression
		Tuberculosis			Any Eye Conditions (Please list):
		Gallstones			
		Liver Disease, Type:			
		Ulcers in Bowel/Stomach			
		Bleeding from Bowels			
		Kidney Disease, Type:			
		Kidney Stones			
		Prostate Problems			
		Gout			
		Arthritis			

SURGERIES

YES	NO	DISEASE	YES	NO	DISEASE
		Tonsils Removed			Back Disc Surgery
		Neck Artery Surgery			Hernia Surgery
		Open Heart Surgery/Catheterization			Other:
		Appendectomy			EYE SURGERIES (Please list) :
		Gallbladder Removal			
		Abdominal Surgery			
		Brown Bone Repair			
		Joint Scope Surgery			
		Joint Replacement of Knee / Hip			

REVIEW OF SYSTEMS

Do you currently have any of the following problems: If yes, please explain:

Chronic fever, unexpected weight loss/gain, fatigue.....	YES	NO	_____
Eye/Ear/Nose/Throat problems (e.g. vision, hearing loss, sinus, sore throat).....	YES	NO	_____
Respiratory problems (e.g. shortness of breath, wheezing, coughing).....	YES	NO	_____
Gastrointestinal problems (e.g. heartburn, abdominal pain, diarrhea, vomiting).....	YES	NO	_____
Urinary problems (e.g. pain or discomfort, blood in urine).....	YES	NO	_____
Skin problems (e.g. rashes, excessive dryness).....	YES	NO	_____
Musculoskeletal problems (e.g. muscle aches, joint pain, swollen joints).....	YES	NO	_____
Neurological problems (e.g. numbness, weakness, headaches, paralysis).....	YES	NO	_____
Psychiatric problems (e.g. depression, anxiety).....	YES	NO	_____

FAMILY HISTORY

YES	NO	DISEASE	RELATION TO YOU	YES	NO	DISEASE	RELATION TO YOU
		Heart Attack				Bleeding Problems	
		High Blood Pressure				Sickle Cell Anemia	
		High Cholesterol				Diabetes/High Blood Sugar	
		Asthma				Thyroid Problems	
		Tuberculosis				Cancer, Type:	
		Liver Disease				Alcohol Abuse	
		Kidney Disease				Anxiety or Depression	
		Gout / Arthritis				EYES (Please list) :	
		Osteoporosis					
		Stroke					
		Epilepsy / Seizure					

OTHER HISTORY

Do you wear Glasses? Yes No Age of current pair: _____

Do you wear contact lenses? Yes No If YES, type: Soft Rigid How long _____

Age of current pair: _____ Type of solution: _____

The following questions are very important and strictly confidential. Please answer them accurately.

Alcohol/Drugs:

YES NO Do you drink? How much? _____ How often? _____

YES NO Do you use drugs? How much? _____ How often? _____ What kind? _____

What drugs have you used in the past? _____

Smoking:

Have you ever smoked: YES NO How many years did you smoke? _____ When did you quit? _____

How many packs per day do you smoke now? _____ Do you use smokeless tobacco: YES NO

The above information is current and correct to the best of my knowledge.

I have reviewed the above history.

Patient/Guardian Signature Date

Physician's Initial Date