Patient Name _____ Date _____

Chief Complaint _____

Is condition due to an injury? ___No ___Yes If yes, please explain

_____

Date of injury or when symptoms began _____

Similar symptoms or injury in the past ___No ___Yes _____

Treatment, if any, so far _____

_____

Please indicate **patient (you)** or family history for the following with an "**X**"

You	Family		Comments	**You**	Family		Comments
		Heart Disease				Tuberculosis	
		Circulatory Problems				Cancer/Tumors	
		High Blood Pressure				Glaucoma	
		Stroke				Cataracts	
		Bleeding Problems				Vertigo/Dizziness	
		Anemia				Seizures	
		Hepatitis/Jaundice				Kidney Problems	
		Rheumatoid Arthritis				Stomach/Bowel Disorder	
		Thyroid Disorder				Other	
		Mental Health Problems				Other	
		Diabetes				Other	
		Emphysema/Asthma					

Allergy: _____ _____

Current Medications: Please provide list with the dosage (**if you need more room please continue on back**)

Drug Name	Dosage (mg)

Surgical History _____

_____

Social History ____ Married ____Single ____Widowed ____Divorced

Occupation _____

Tobacco use ___No ___Yes If yes, how much _____

Alcohol use ___No ___Yes If yes, how much _____

Height _____ Weight _____ ___Right handed ___Left handed

FEMALE patients - could you be pregnant ____No ____ Yes

Drug Name	Dosage (mg),etc.	How Often