

Name _____ D.O.B. _____ Date _____

FOR FEMALES: Is there a possibility you are pregnant? Yes No Date of Last Period: _____

Chief Complaint _____

PERSONAL HISTORY: Illnesses	Yes	No
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>
Chicken Pox	<input type="checkbox"/>	<input type="checkbox"/>
Smallpox	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>
Bone Disease	<input type="checkbox"/>	<input type="checkbox"/>
Polio/Meningitis	<input type="checkbox"/>	<input type="checkbox"/>
Gonorrhea/Syphilis	<input type="checkbox"/>	<input type="checkbox"/>
Gallbladder disease	<input type="checkbox"/>	<input type="checkbox"/>
Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Bladder disease	<input type="checkbox"/>	<input type="checkbox"/>
Epilepsy	<input type="checkbox"/>	<input type="checkbox"/>
Migraines	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>
What type? _____		
Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Nervous Breakdown	<input type="checkbox"/>	<input type="checkbox"/>
Any poisoning	<input type="checkbox"/>	<input type="checkbox"/>
What type? _____		
Asthma/Hay fever	<input type="checkbox"/>	<input type="checkbox"/>
Eczema/Hives	<input type="checkbox"/>	<input type="checkbox"/>
AIDS	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
Blood transfusion	<input type="checkbox"/>	<input type="checkbox"/>

ALLERGIES:	Yes	No
Penicillin	<input type="checkbox"/>	<input type="checkbox"/>
Sulfa	<input type="checkbox"/>	<input type="checkbox"/>
Aspirin/Codeine	<input type="checkbox"/>	<input type="checkbox"/>
Mycins	<input type="checkbox"/>	<input type="checkbox"/>
Methiolate	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus/Serums	<input type="checkbox"/>	<input type="checkbox"/>
Adhesive Tape	<input type="checkbox"/>	<input type="checkbox"/>
Cosmetics	<input type="checkbox"/>	<input type="checkbox"/>
Any drug _____		

Any food _____		

INJURIES:	Yes	No
Broken bones	<input type="checkbox"/>	<input type="checkbox"/>
Sprains	<input type="checkbox"/>	<input type="checkbox"/>
Lacerations	<input type="checkbox"/>	<input type="checkbox"/>
Concussion	<input type="checkbox"/>	<input type="checkbox"/>
Head injury	<input type="checkbox"/>	<input type="checkbox"/>

WEIGHT: _____

HEIGHT: _____

WITHIN THE LAST YEAR HAVE YOU HAD:	Yes	No
Frequent headaches	<input type="checkbox"/>	<input type="checkbox"/>
Severe headaches	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>
Blurred Vision	<input type="checkbox"/>	<input type="checkbox"/>
Spots before eyes	<input type="checkbox"/>	<input type="checkbox"/>
Infected eyes	<input type="checkbox"/>	<input type="checkbox"/>
Earaches	<input type="checkbox"/>	<input type="checkbox"/>
Ear discharge	<input type="checkbox"/>	<input type="checkbox"/>
ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>
Decrease hearing	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent nose bleed	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent head cold	<input type="checkbox"/>	<input type="checkbox"/>
Sinus trouble	<input type="checkbox"/>	<input type="checkbox"/>
Nasal odors	<input type="checkbox"/>	<input type="checkbox"/>
Strange taste	<input type="checkbox"/>	<input type="checkbox"/>
Loss in taste	<input type="checkbox"/>	<input type="checkbox"/>
Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
Persistent Difficulty Swallowing	<input type="checkbox"/>	<input type="checkbox"/>
Enlarged glands	<input type="checkbox"/>	<input type="checkbox"/>
Sore throats	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent	<input type="checkbox"/>	<input type="checkbox"/>

	Yes	No
Chronic Cough	<input type="checkbox"/>	<input type="checkbox"/>
Coughed up blood	<input type="checkbox"/>	<input type="checkbox"/>
Coughing laying	<input type="checkbox"/>	<input type="checkbox"/>
Waking up short of breath	<input type="checkbox"/>	<input type="checkbox"/>
Purple fingers	<input type="checkbox"/>	<input type="checkbox"/>
Heart fluttering	<input type="checkbox"/>	<input type="checkbox"/>
Swelling hands	<input type="checkbox"/>	<input type="checkbox"/>
Swelling feet	<input type="checkbox"/>	<input type="checkbox"/>
Swelling ankles	<input type="checkbox"/>	<input type="checkbox"/>
Stomach pain	<input type="checkbox"/>	<input type="checkbox"/>
Recurrent	<input type="checkbox"/>	<input type="checkbox"/>
Belching	<input type="checkbox"/>	<input type="checkbox"/>
Heartburn	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
Nausea	<input type="checkbox"/>	<input type="checkbox"/>
Vomiting blood	<input type="checkbox"/>	<input type="checkbox"/>
Abdominal cramping	<input type="checkbox"/>	<input type="checkbox"/>
Sores in mouth	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding in gums	<input type="checkbox"/>	<input type="checkbox"/>
Sore gums	<input type="checkbox"/>	<input type="checkbox"/>
Chest pain	<input type="checkbox"/>	<input type="checkbox"/>