**PLEASE PRINT**

Today's Date ____________________

**NAME:** ______________________________ **DATE OF BIRTH:** ______________ **AGE:** __________

**ARE YOU RIGHT OR LEFT HANDED?** ____________

**MEDICATIONS:** (LIST ALL, INCLUDING OVER-THE-COUNTER DRUGS)

1.) ____________________
2.) ____________________
3.) ____________________
4.) ____________________
5.) ____________________

**ALLERGIES:** (PLEASE LIST)

❑ NONE

1.) ____________________
2.) ____________________
3.) ____________________
4.) ____________________
5.) ____________________

Are you taking Coumadin? ❑ Yes ❑ No

What is the reason for this consultation? ________________________________________

________________________________________

________________________________________

**SYSTEM REVIEW:** (Please circle any you have ever had or are now being treated for)

**A. NEUROLOGIC**

Stroke
Head Injury
Neck Pain
Seizure
Headaches
Loss of Consciousness
Back Pain
Tremor
Parkinson's Disease
Balance Trouble
Numbness/Tingling
Trouble Sleeping (Snoring, Restless Legs, Fall asleep in daytime, Insomnia)

**B. CARDIOVASCULAR**

Chest Pain
Irregular Rhythm
Heart Valve Replacement
Heart Attack
High Blood Pressure
Angina
Murmur
Rheumatic Heart Disease
Pacemaker

**C. LIVER**

Hepatitis
Jaundice

**D. RESPIRATORY**

Asthma
Pneumonia
Emphysema
Shortness of Breath
Chronic Bronchitis
TB

**E. OTHER**

Cancer
Arthritis
Anxiety
Anemia
Fever
Bladder Problem
Diabetes
Ulcer
Depression
Kidney Problem/Dialysis
Low Energy Level
Thyroid Disease
Bleeding Disorder
Muscle Disease
Rash
Claustrophobia
Diarrhea
Constipation
Weight Gain/Loss
Alcohol and/or Drug Dependency
Implanted Medical Device

**LIST SERIOUS INJURIES** (broken bones, accidents, etc.):

1.) ______________ 2.) ______________ 3.) ______________

**LIST PREVIOUS SURGERIES:**

1.) ______________ 3.) ______________ 5.) ______________

2.) ______________ 4.) ______________ 6.) ______________

**LIST HOSPITALIZATIONS** (other than for surgery)

1.) ______________ 3.) ______________ 5.) ______________

2.) ______________ 4.) ______________ 6.) ______________

**PLEASE TURN OVER**

Any problems with anesthesia? ______________________________

Have you ever had a blood transfusion? ❑ No ❑ Yes If so, why? ______________________________

______________________________

**SOCIAL HISTORY**

Marital Status (Circle One) S M W D Sep.

**TOBACCO USE:** ❑ No ❑ Yes Current or Past? ______________

If so, what kind: ______________ How much? ______________ How long ______________

**ALCOHOL USE:** ❑ No ❑ Yes Current or Past? ______________

If so, what kind: ______________ How much? ______________ How long ______________

Do you live with your spouse? ❑ No ❑ Yes

Do you have dependents at home? ❑ No ❑ Yes

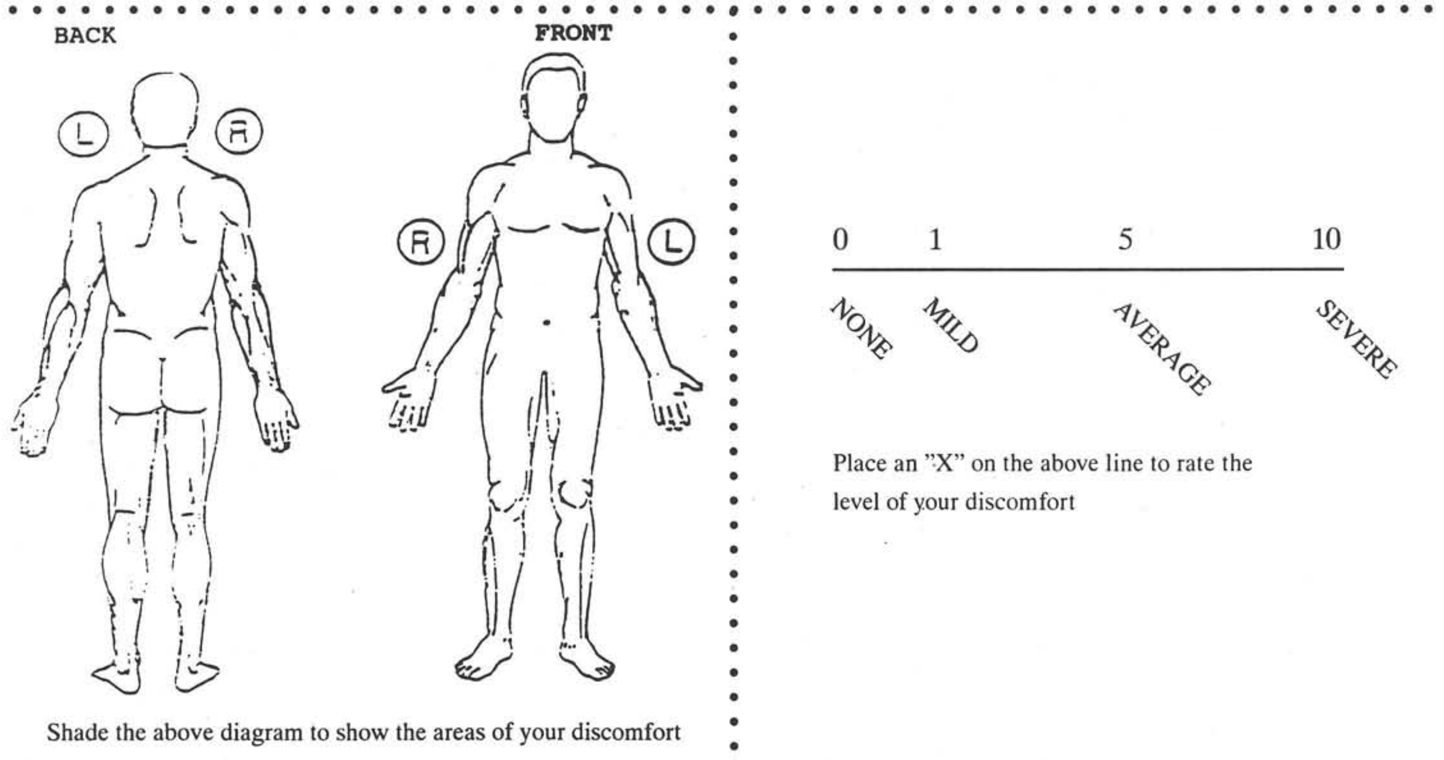
Are you employed? ❑ No ❑ Yes

Highest grade completed in school? ______________________________

Have you recently lost time at work due to health? ______________ If so, how much? ______________

CHECK ANY ILLNESSES WHICH HAVE OCCURED IN **BLOOD** RELATIVES:

| | | | |
|---|---|---|---|
| ❑ Diabetes | ❑ Cancer | ❑ Stroke | ❑ Heart Disease |
| ❑ High Blood Pressure | ❑ Arthritis | ❑ Bleeding Tendency | ❑ Kidney Disease |
| ❑ Depression/Anxiety | ❑ Parkinson s Disease | ❑ TB | ❑ Convulsions |
| ❑ Epilepsy | ❑ Headaches | ❑ Tremor | ❑ Schizophrenia |
| ❑ Bi polar/Manic Depression | | ❑ Other ______________ | |




Shade the above diagram to show the areas of your discomfort

Place an "X" on the above line to rate the level of your discomfort

Referring Doctor: ______________________________ Family Doctor: ______________________________

______________________________

(Signature of person completing this form)