Name: _____ **Date of Birth**_____/_____/_____

Why are you here today?

Who referred you to this practice?

List any medical problems

List any previous surgeries, if any

List any medications that you are taking:

Are you allergic to any medications?

Circle any of the following conditions that you have experienced within the last six months:

Prolonged fever Prolonged fatigue Significant headache Impaired vision Impaired hearing

Dental problems Shortness of breath Chest pain Palpitations Chronic cough Anxiety

Unexplained weight loss Fractures Scalp hair loss Excessive thirst Fainting Joint pain

Leg swelling Frequent urination Difficulty swallowing Abdominal pain Depressed mood

Constipation Diarrhea

Medical problems Mother_____ Father _____ Siblings _____

For women age when period began _____ date of last period _____ age at menopause_____

Where were you born (country) _____

What is your occupation? If retired, what was your occupation? _____