

Please indicate reason for your appointment:		
Current medications, including over the counter preparations, you have taken recently. Please indicate how many mg per dose and how many doses per day.		
Drug allergies (if so, describe type of reaction):		
Any medical conditions / illnesses?		
Any surgeries, hospitalizations?		
Any recent x-rays or other tests?		
Pharmacy name and phone#:	Does anyone in your family have any of the following? If so, specify which family member (e.g., mother, sibling, children, etc.)	
Do you smoke? How much?	Heart disease	Stroke
Did you ever smoke? For how long?	High blood pressure	Dementia
Do you drink alcohol? How much?	Diabetes	Muscle disorder
Do you use recreational drugs?	Cancer (what organ)	Sensory disorder
Do you exercise? How much?	Arthritis	Incoordination
Date of last menses: Could you be pregnant?	Bleeding disorder	Shaking
Are you right handed or left?	Kidney disease	Seizures
Right___ Left___	Thyroid disease	Headaches
Height	Brain tumors	Mental illness
Weight	Aneurysm	Attention deficit / hyperactivity
Comments:		

Have you recently experienced any of the following? (Please use the bottom of this page to elaborate when pertinent)

- | | | | | |
|---|---|--|---|---|
| <input type="checkbox"/> Y <input type="checkbox"/> N Fever | <input type="checkbox"/> Y <input type="checkbox"/> N Nausea or Vomiting | <input type="checkbox"/> Y <input type="checkbox"/> N Sexual Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Sleeping | <input type="checkbox"/> Y <input type="checkbox"/> N Dizziness or Vertigo |
| <input type="checkbox"/> Y <input type="checkbox"/> N Weight Loss/Gain | <input type="checkbox"/> Y <input type="checkbox"/> N Chest Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Joint Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Anxiety | <input type="checkbox"/> Y <input type="checkbox"/> N Clumsiness |
| <input type="checkbox"/> Y <input type="checkbox"/> N Change in Appetite | <input type="checkbox"/> Y <input type="checkbox"/> N Palpitations | <input type="checkbox"/> Y <input type="checkbox"/> N Bone Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Depression | <input type="checkbox"/> Y <input type="checkbox"/> N Unsteadiness |
| <input type="checkbox"/> Y <input type="checkbox"/> N Visual Change | <input type="checkbox"/> Y <input type="checkbox"/> N Shortness of Breath | <input type="checkbox"/> Y <input type="checkbox"/> N Neck / Low Back Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Headaches | <input type="checkbox"/> Y <input type="checkbox"/> N Weakness |
| <input type="checkbox"/> Y <input type="checkbox"/> N Hearing Loss | <input type="checkbox"/> Y <input type="checkbox"/> N Allergies | <input type="checkbox"/> Y <input type="checkbox"/> N Shooting Pain / Sciatica | <input type="checkbox"/> Y <input type="checkbox"/> N Change in Mental Acuity | <input type="checkbox"/> Y <input type="checkbox"/> N Numbness or Tingling |
| <input type="checkbox"/> Y <input type="checkbox"/> N Ear ache | <input type="checkbox"/> Y <input type="checkbox"/> N Constipation | <input type="checkbox"/> Y <input type="checkbox"/> N Muscle Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Memory Problems | <input type="checkbox"/> Y <input type="checkbox"/> N Stiffness or Slowness |
| <input type="checkbox"/> Y <input type="checkbox"/> N Ringing in Ears | <input type="checkbox"/> Y <input type="checkbox"/> N Diarrhea | <input type="checkbox"/> Y <input type="checkbox"/> N Skin Problem | <input type="checkbox"/> Y <input type="checkbox"/> N Hallucinations | <input type="checkbox"/> Y <input type="checkbox"/> N Shaking |
| <input type="checkbox"/> Y <input type="checkbox"/> N Cough | <input type="checkbox"/> Y <input type="checkbox"/> N Abdominal Pain | <input type="checkbox"/> Y <input type="checkbox"/> N Bleeding or Bruising | <input type="checkbox"/> Y <input type="checkbox"/> N Agitation or Confusion | <input type="checkbox"/> Y <input type="checkbox"/> N Other_____ |
| <input type="checkbox"/> Y <input type="checkbox"/> N Sore Throat | <input type="checkbox"/> Y <input type="checkbox"/> N Black or Tarry Stools | <input type="checkbox"/> Y <input type="checkbox"/> N Anemia | <input type="checkbox"/> Y <input type="checkbox"/> N Personality Changes | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Change in Smell | <input type="checkbox"/> Y <input type="checkbox"/> N Blood in Stools | <input type="checkbox"/> Y <input type="checkbox"/> N Fatigue | <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Speaking | |
| <input type="checkbox"/> Y <input type="checkbox"/> N Difficulty Swallowing | <input type="checkbox"/> Y <input type="checkbox"/> N Problems Urinating | <input type="checkbox"/> Y <input type="checkbox"/> N Sleepiness / Sedation | <input type="checkbox"/> Y <input type="checkbox"/> N Change in Taste | |

Reviewed by: _____ Date: _____