NAME: Desired Pronoun:

ADDRESS:

EMAIL ADDRESS:

PHONE NUMBER: DATE OF BIRTH:

EMERGENCY CONTACT:

Name: Phone number:

REFERRED BY:

Would you like to be added to the Newsletter? YES ☐ NO ☐

INSURANCE CARRIER:

MEMBER ID:

GROUP #

Are you allergic to any medications or food? YES ☐ NO ☐ Please list:

PAST MEDICAL HISTORY

YES	NO		YES	NO	
☐	☐	Angina	☐	☐	Hepatitis
☐	☐	Arthritis	☐	☐	High Blood Pressure
☐	☐	Asthma	☐	☐	High Cholesterol
☐	☐	Blood clots	☐	☐	HIV/AIDS
☐	☐	Cancer	☐	☐	Kidney disease/stones
☐	☐	COVID - 19	☐	☐	Lyme disease
☐	☐	Depression	☐	☐	Stroke
☐	☐	Diabetes	☐	☐	Thyroid Disease
☐	☐	Epilepsy	☐	☐	Tuberculosis
☐	☐	Heart Attack	OTHER:		
☐	☐	Heart Disease			
☐	☐	Headaches			

MAIN COMPLAINT:

CURRENT MEDICATIONS:

SURGERIES/HOSPITALIZATIONS:

ROS	Please circle all that **CURRENTLY** apply
CONSTITUTIONAL	weight loss or gain / runs warm / runs cold / increase or decrease appetite, / sweats easily / night sweats / catch colds easily / low energy / high energy
EYES	Pain / floaters / dry / discharge / change in vision
ENT	Blocked ears / ear pain / hearing loss / tinnitus sinus congestion / post nasal drip / nose bleeds / nasal discharge sore throat / hoarseness
CARDIOVASCULAR	Chest pain / palpitations / rapid heart rate / irregular heart rate / poor circulation / swelling in legs or feet
RESPIRATORY	Shortness of breath / chronic cough / coughing blood / coughing phlegm
GASTROINTESTINAL	Nausea / vomiting / gas / bloating / heart burn / difficulty swallowing / diarrhea / constipation / blood in stool / mucous in stool
GENITOURINARY	Incontinence / frequent urination / night urination / chronic UTI / incomplete urination / blood in urine / pain with urination / weak stream / erectile dysfunction
GYNECOLOGICAL	Painful periods / irregular periods / amenorrhea / miscarriage / fibroids / ovarian cysts
SKIN	Hives / rashes / eczema / dryness / hair loss
MUSCULOSKELETAL	Pain location: Joint pain / muscle pain / muscle weakness / leg cramps / spasm / joint swelling
PSYCHIATRIC	Anxiety / depression / suicidal thoughts / panic attacks
ENDOCRINE	Goiter / heat or cold intolerance / thirst / excessive sweating

NEUROLOGICAL	Migraines / seizures / tremors / numbness / dizziness / loss of balance / slurred speech
HEM/LYMPHATIC	Bruise easily / low white or red blood cell count / swollen lymph nodes / blood clots
ALLERGIC/IMMUN	Seasonal allergies / frequent infections

SOCIAL HISTORY:

Current Occupation:

Tobacco use - How may packs per day / week?

Alcohol consumption - How many drinks per day / week?

Caffeine consumption - How many cups per day / week?

Other:

FAMILY HISTORY: (Please list any known medical problems)

Father:

Mother:

Siblings:

Your children:

ADDITIONAL INFORMATION:

Signature of Patient:	Date:
Signature of Provider	Date: