

NEW PATIENT CLINICAL INFORMATION

NAME: _____

PLEASE LIST YOUR PRIMARY CARE DOCTOR: _____

PLEASE LIST YOUR PHARMACY AND PHONE NUMBER: _____

PLEASE LIST OTHER PHYSICIANS THAT ARE CURRENTLY TREATING YOU:

PLEASE LIST ALL MEDICATIONS AND EYE DROPS YOU ARE CURRENTLY TAKING:

PLEASE LIST ANY DRUG ALLERGIES: _____

PLEASE LIST ANY FOOD ALLERGIES: _____

PLEASE LIST ANY SURGERIES YOU HAVE HAD, ALONG WITH THEIR DATES:

OTHER THAN SURGERIES, PLEASE LIST ANY TREATMENTS OR HOSPITALIZATIONS, WITH DATES, THAT YOU HAVE HAD:

PLEASE LIST YOUR KNOWN MEDICAL PROBLEMS: (EX: HIGH BLOOD PRESSURE, DIABETES, ETC)

CHILDHOOD: _____

ADULTHOOD: _____

PLEASE LIST ANY ILLNESSES YOUR BLOOD RELATIVES HAVE HAD:

FATHER: _____

MOTHER: _____

BROTHER/SISTER: _____

AUNT/UNCLE: _____

GRANDPARENTS: _____

IF YOU SMOKE, HOW MANY PACKS PER DAY: _____ YEARS SMOKED: _____

DO YOU SMOKE CIGARS: YES / NO CHEW TOBACCO: YES / NO USE SNUFF: YES / NO

IF YOU DRINK ALCOHOL, WHAT DO YOU DRINK AND HOW OFTEN:

MARITAL STATUS: SINGLE ___ MARRIED ___ WIDOWED ___ DIVORCED ___ SEPARATED ___

NUMBER OF CHILDREN: _____ AGES: _____

REASON FOR DOCTOR'S APPOINTMENT TODAY: _____

SIGNATURE: _____ DATE: _____

REVIEW OF SYSTEMS

DO YOU HAVE ANY OF THE FOLLOWING TODAY?
CIRCLE YES OR NO.

NAME: _____

CONSTITUTIONAL SYMPTOMS

FEVER YES NO
CHILLS YES NO
WEIGHT LOSS YES NO
OTHER: _____

MUSCULOSKELETAL

JOINT PAIN YES NO
NECK PAIN YES NO
BACK PAIN YES NO
OTHER: _____

EYES

BLURRED VISION YES NO
DOUBLE VISION YES NO
PAIN YES NO
OTHER: _____

NEUROLOGICAL

TREMORS YES NO
DIZZY SPELLS YES NO
NUMBNESS/TINGLING YES NO
OTHER: _____

EARS/ NOSE/ THROAT/ MOUTH

EAR INFECTION YES NO
SORE THROAT YES NO
SINUS PROBLEMS YES NO
OTHER: _____

PSYCHOLOGICAL

DEPRESSED YES NO
ANXIOUS YES NO
OTHER: _____

CARDIOVASCULAR

CHEST PAIN YES NO
PALPITATIONS YES NO
OTHER: _____

HEMATOLOGIC/LYMPHATIC

LYMPH NODE PAIN/ SWELLING YES NO
BLOOD CLOTTING PROBLEM YES NO
OTHER: _____

RESPIRATORY

WHEEZING YES NO
COUGH YES NO
SHORTNESS OF BREATH YES NO
OTHER: _____

ENDOCRINE

HEAT/COLD INTOLERANCE YES NO
EXCESSIVE THIRST YES NO
TIRED/SLUGGISH YES NO
OTHER: _____

GASTROINTESTINAL

ABDOMINAL PAIN YES NO
BLOODY OR DARK TARRY STOOL YES NO
DIARRHEA YES NO
CONSTIPATION YES NO
OTHER: _____

INTEGUMENT/SKIN

RASH YES NO
PERSISTANT ITCH YES NO
BOILS YES NO
EXCESSIVE SCARRING YES NO
OTHER: _____

GENITOURINARY

DISCHARGE YES NO
PAIN WITH URINATION YES NO
FREQUENCY OF URINATION YES NO
OTHER: _____

ALLERGY/IMMUNE SYSTEM

FOOD ALLERGY YES NO
HAY FEVER YES NO
HIV YES NO
OTHER: _____

SIGNATURE: _____ DATE: _____