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 HOSPITILIZATIONS, 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?
SELECT YES OR NO.

NAME: _____

CONSTITUTIONAL SYMPTOMS
FEVER ☐ YES ☐ NO
CHILLS ☐ YES ☐ NO
WEIGHT LOSS ☐ YES ☐ NO
OTHER: _____

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

EARS/ NOSE/ THROAT/ MOUTH
EAR INFECTION ☐ YES ☐ NO
SORE THROAT ☐ YES ☐ NO
SINUS PROBLEMS ☐ YES ☐ NO
OTHER: _____

CARDIOVASCULAR
CHEST PAIN ☐ YES ☐ NO
PALPITATIONS ☐ YES ☐ NO
OTHER: _____

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

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

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

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

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

PSYCHOLOGICAL
DEPRESSED ☐ YES ☐ NO
ANXIOUS ☐ YES ☐ NO
OTHER: _____

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

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

INTEGUMENT/SKIN
RASH ☐ YES ☐ NO
PERSISTANT ITCH ☐ YES ☐ NO
BOILS ☐ YES ☐ NO
EXCESSIVE SCARRING ☐ YES ☐ NO
OTHER: _____

ALLERGY/IMMUNE SYSTEM
FOOD ALLERGY ☐ YES ☐ NO
HAY FEVER ☐ YES ☐ NO
HIV ☐ YES ☐ NO
OTHER: _____

SIGNATURE: _____ DATE: _____

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