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?
CIRCLE 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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