Patient Name:_____ Today's date: ____/____/____

Please list the name(s) of your doctor(s)

Name: _____ Name: _____

Address:_____ Address:_____

_____ _____

Phone: _____ Phone: _____

List all medications you take: **Including over the counter medications, vitamins, or herbal supplements:**

_____ _____

_____ _____

_____ _____

_____ _____

List all allergies to medications: _____

Do you smoke? _____ If yes, how much? _____ Do you drink: _____ If yes, how much? _____

What is your height _____ Weight _____

Do you or any of your family members have the following illnesses?

	Myself	Family members (indicate relationship to patient)
Bleeding tendency	_____	_____
Diabetes	_____	_____
High blood pressure	_____	_____
Heart disease	_____	_____
Asthma / Emphysema	_____	_____
Cancer (if yes, what type)	_____	_____
Hepatitis / Liver disease	_____	_____
Thyroid disease	_____	_____
Kidney disease	_____	_____
Seizures or stroke	_____	_____
HIV or immune deficiency	_____	_____
Other	_____	_____

Please list all previous surgeries and hospitalizations (with dates if known)

_____

_____

_____

Review of Systems: Are you currently experiencing any of the following symptoms?

			****Do not write in this box, doctor's use only****	
			Problem list w/dates	Surgeries with dates
Fatigue	Yes	No		
Vision changes	Yes	No		
Chest pain / palpitations	Yes	No		
Shortness of breath	Yes	No		
Digestive problems	Yes	No		
Urinary Difficulties	Yes	No		
Muscle / Joint pains	Yes	No		
Changes in skin	Yes	No		
Mood changes	Yes	No		
Bruising / Bleeding	Yes	No		