Name:
DOB:

Medication List

Name of the Medication	Dose	Frequency	Doctor

List any herbal supplements or vitamins you are taking:

_____

_____

Family History

Please list any history of family illnesses / diseases:

Mother: _____ Father: _____ Siblings: _____

Grandmother: _____ Grandfather: _____ Children: _____

Social History (circle all that apply)

Exercise: Daily Weekly Monthly Rarely Never

Type_____ Duration_____

Smoking: Current every day smoker Current some day smoker Former Smoker
Never Smoker Chewing Tobacco

*If yes, for how long _____

Drink Alcohol: No Yes

Drug use: Never Quit Yes *If yes, what type(s) _____

Review of Systems

Please **circle** symptoms that you are **currently experiencing TODAY.**

Fever / Chills
Fatigue
Vision changes
Sore throat
Nasal Stuffiness / Drainage
Hearing changes / Ear pain
Anxiety
Chest pain / pressure
Palpitations
Shortness of breath
Difficulty breathing
Cough
Wheezing
Depression
Nausea / Vomiting
Diarrhea / Constipation
Urinary pain / urgency / incontinence
Joint pain / Muscle weakness
Changes to skin, hair, or nails
Numbness: Arms / Hands / Legs/ Feet
Dizziness

Please turn over…->