



PATIENT MEDICAL INFORMATION SHEET

Why have you come to see our doctor today? _____

Please write down any medications that you are currently taking, along with doses and schedules: _____

Please write down any medications to which you have had a reaction or allergy: _____

Have you ever had surgery, or been hospitalized? If so where, when and why? _____

In the boxes below, please check symptoms that occur to you often or have recently begun.

- | | | | |
|---|---|--|--|
| <input type="checkbox"/> Weight gain or loss | <input type="checkbox"/> Loss of taste | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Rashes |
| <input type="checkbox"/> Fever | <input type="checkbox"/> Loss of smell | <input type="checkbox"/> Indigestion | <input type="checkbox"/> Easy Bruising |
| <input type="checkbox"/> Night Sweats | <input type="checkbox"/> Painful Swallowing | <input type="checkbox"/> Difficulty swallowing | <input type="checkbox"/> Change in vision |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Numbness or Paralysis | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Vomiting blood |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Heat or cold intolerance | <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Bloody stools |
| <input type="checkbox"/> Double vision | <input type="checkbox"/> Ear pain | <input type="checkbox"/> Frequent ear infections | <input type="checkbox"/> Painful urination |
| <input type="checkbox"/> Dry eyes | <input type="checkbox"/> Enlarged lymph nodes | <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Hearing loss | <input type="checkbox"/> Ringing in the ears | <input type="checkbox"/> Sneezing, runny nose | <input type="checkbox"/> Palpitations |
| <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Irregular heart beat | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Pain in muscles |
| <input type="checkbox"/> Sore joints | <input type="checkbox"/> Frequent sore throats | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Weak muscles |
| <input type="checkbox"/> Coughing up blood | <input type="checkbox"/> Feelings of Depression | <input type="checkbox"/> Tire easily | <input type="checkbox"/> Snoring |
| <input type="checkbox"/> Change of skin or hair texture | | | |

Please check the box below next to any of the following medical problems with which you have been diagnosed:

- | | | |
|---|--|---|
| <input type="checkbox"/> Hypertension (High Blood Pressure) | <input type="checkbox"/> Liver Dysfunction | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Diabetes Mellitus | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Muscle Disease |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Chronic Renal Failure | <input type="checkbox"/> Allergic Rhinitis |
| <input type="checkbox"/> Angina | <input type="checkbox"/> Dialysis | <input type="checkbox"/> Immune Abnormalities |
| <input type="checkbox"/> Arrhythmia's | <input type="checkbox"/> Prostate Enlargement | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Glaucoma |
| <input type="checkbox"/> COPD, Emphysema | <input type="checkbox"/> Gout | <input type="checkbox"/> Bleeding Disorders |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Esophageal Reflux | <input type="checkbox"/> Lupus, Scleroderma | <input type="checkbox"/> Peptic Ulcer Disease |
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Other _____ | |

Please check the box below if any of these diseases run in your immediate family (parents, grandparents, brothers or sisters):

- | | | |
|--|---------------------------------------|--|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Lung Disease | <input type="checkbox"/> Bleeding Problems |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer | <input type="checkbox"/> Hearing Loss |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Other _____ |

Please check the box if you use the following: Cigarettes (How many packs per day) _____ Other tobacco products
 Alcohol Drugs

Please sign your name _____ Today's Date _____