



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? If so where? What?

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

- | | | |
|---|--|---|
| <input type="checkbox"/> WEIGHT GAIN/ LOSS | <input type="checkbox"/> RINGING IN EARS | <input type="checkbox"/> INDIGESTION |
| <input type="checkbox"/> FEVER | <input type="checkbox"/> FREQUENT SORE THROATS | <input type="checkbox"/> DIFFICULTY SWALLOWING |
| <input type="checkbox"/> NIGHT SWEATS | <input type="checkbox"/> HOARSENESS | <input type="checkbox"/> VOMITING BLOOD |
| <input type="checkbox"/> LOSS OF APPETITE | <input type="checkbox"/> DRY MOUTH | <input type="checkbox"/> BLOODY STOOLS |
| <input type="checkbox"/> FATIGUE | <input type="checkbox"/> FREQUENT EAR INFECTIONS | <input type="checkbox"/> FREQUENT URINATION |
| <input type="checkbox"/> CHANGE IN SKIN/ HAIR | <input type="checkbox"/> SNEEZING/ RUNNY NOSE | <input type="checkbox"/> BLOOD IN URINE |
| <input type="checkbox"/> RASHES | <input type="checkbox"/> CHANGE IN VISION | <input type="checkbox"/> PAINFUL URINATION |
| <input type="checkbox"/> BRUISING | <input type="checkbox"/> COUGHING UP BLOOD | <input type="checkbox"/> SORE JOINTS |
| <input type="checkbox"/> DOUBLE VISION | <input type="checkbox"/> WHEEZING | <input type="checkbox"/> PAIN IN MUSCLES |
| <input type="checkbox"/> DRY EYES | <input type="checkbox"/> SNORING | <input type="checkbox"/> WEAK MUSCLES |
| <input type="checkbox"/> HEARING LOSS | <input type="checkbox"/> IRREGULAR HEARTBEAT | <input type="checkbox"/> SEIZURES |
| <input type="checkbox"/> NOSE BLEEDS | <input type="checkbox"/> SHORTNESS OF BREATH | <input type="checkbox"/> NUMBNESS/ PARALYSIS |
| <input type="checkbox"/> LOSS OF TASTE | <input type="checkbox"/> CHEST PAIN | <input type="checkbox"/> FEELINGS OF DEPRESSION |
| <input type="checkbox"/> LOSS OF SMELL | <input type="checkbox"/> PALPITATIONS | <input type="checkbox"/> HEAT/COLD INTOLERANCE |
| <input type="checkbox"/> EAR PAIN | <input type="checkbox"/> PAINFUL SWALLOWING | <input type="checkbox"/> ENLARGED LYMPH NODES |

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

- | | | |
|---|--|---|
| <input type="checkbox"/> HYPERTENSION | <input type="checkbox"/> ANEMIA | <input type="checkbox"/> MUSCLE DISEASE |
| <input type="checkbox"/> DIABETES MELLITUS I | <input type="checkbox"/> LIVER DYSFUNCTION | <input type="checkbox"/> ALLERGIC RHINITIS |
| <input type="checkbox"/> DIABETES MELLITUS II | <input type="checkbox"/> KIDNEY STONES | <input type="checkbox"/> IMMUNE ABNORMALITIES |
| <input type="checkbox"/> HEART DISEASE | <input type="checkbox"/> CHRONIC RENAL FAILURE | <input type="checkbox"/> AIDS |
| <input type="checkbox"/> ANGINA | <input type="checkbox"/> DIALYSIS | <input type="checkbox"/> GLAUCOMA |
| <input type="checkbox"/> ARRHYTHMIAS | <input type="checkbox"/> PROSTATE ENLARGEMENT | <input type="checkbox"/> BLEEDING DISORDERS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> THYROID DISEASE | <input type="checkbox"/> HEARING LOSS |
| <input type="checkbox"/> COPD | <input type="checkbox"/> GOUT | <input type="checkbox"/> PEPTIC ULCER DISEASE |
| <input type="checkbox"/> EMPHYSEMA | <input type="checkbox"/> ARTHRITIS | <input type="checkbox"/> STROKE |
| <input type="checkbox"/> TUBERCULOSIS | <input type="checkbox"/> LUPUS/ SCLERODERMA | <input type="checkbox"/> CANCER: _____ |
| <input type="checkbox"/> ESOPHAGEAL REFLUX | <input type="checkbox"/> SEIZURES | <input type="checkbox"/> OTHER: _____ |
| <input type="checkbox"/> HEPATITIS | <input type="checkbox"/> MULTIPLE SCLEROSIS | <input type="checkbox"/> OTHER |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> PARALYSIS | <input type="checkbox"/> NONE |

Please check the box next to any diseases that run in your immediate family (parents, grandparents, siblings)

- | | | |
|--|---------------------------------------|--|
| <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: _____ |

FLU VACCINE: YEAR _____

PNEUMONIA VACCINE: YEAR _____

Please check the box if you use the following:

- | | | | |
|---|----------------------------------|--------------------------------|--|
| <input type="checkbox"/> CIGARETTES: CIRCLE ONE | <input type="checkbox"/> ALCOHOL | <input type="checkbox"/> DRUGS | <input type="checkbox"/> OTHER TOBACCO |
| CURRENT? FORMER? | | | |

PLEASE SIGN YOUR NAME: _____ TODAY'S DATE: _____