# HEALTH SUMMARY

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**Patient's Name (PLEASE PRINT):** _____

**Today's Date:** _____ **DOB:** _____ **SS#:** _____

**REVIEW OF SYSTEMS:** Are you CURRENTLY experiencing any of the following? Please check ALL boxes that apply.

## CONSTITUTIONAL
- ☐ Good heath lately
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Fever
- ☐ Chills
- ☐ Body aches
- ☐ Fatigue
- ☐ Other_____

## EYES
- ☐ Eye disease or injury
- ☐ Wear glasses
- ☐ Contacts
- ☐ Glaucoma
- ☐ Blurred vision
- ☐ Double vision
- ☐ Other_____

## EAR, NOSE & THROAT
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Other_____

## CARDIO/VASCULAR
- ☐ Heart trouble
- ☐ Chest pain
- ☐ Palpitations
- ☐ Varicose veins
- ☐ Lower limb swelling
- ☐ Dizziness
- ☐ Other_____

## RESPIRATORY
- ☐ Frequent coughing
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Asthma/Wheezing
- ☐ Other_____

## GASTROINTESTINAL
- ☐ Loss of appetite
- ☐ Change in bowel movements
- ☐ Blood in stool
- ☐ Stomach pain
- ☐ Nausea
- ☐ Vomiting
- ☐ Heartburn
- ☐ Other_____

## GENITOURINARY
- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Change in force of stream
- ☐ Incontinence or dribbling
- ☐ Kidney stones
- ☐ Sexual difficulty
- ☐ Other_____

## MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Muscle pain/cramps
- ☐ Back pain
- ☐ Limb pain
- ☐ Other_____

## SKIN
- ☐ Itching
- ☐ Rash
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Other_____

## NEUROLOGICAL
- ☐ Frequent or recurrent headaches
- ☐ Light headed or dizziness
- ☐ Convulsions/seizures
- ☐ Numbness or tingling
- ☐ Extremity Weakness
- ☐ Memory loss
- ☐ Other_____

## HEMATOLOGIC / LYMPHATIC
- ☐ Slow to heal after cuts
- ☐ Easily bruise or bleed
- ☐ Anemia
- ☐ Past blood transfusion
- ☐ Enlarged glands
- ☐ Other_____

## ENDOCRINE
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive thirst/urination
- ☐ Heat intolerance
- ☐ Cold intolerance
- ☐ Other_____

## ALLERGIES
- ☐ Runny/Stuffy nose
- ☐ Watery eyes
- ☐ Itchy nose, eyes and roof of mouth
- ☐ Sneezing
- ☐ Pressure in the nose and cheeks
- ☐ Ear fullness and popping
- ☐ Hives
- ☐ Other_____

## MENTAL WELLNESS
- ☐ Nervousness
- ☐ Depression
- ☐ Sleeping too much
- ☐ Unable to fall/stay asleep
- ☐ Other_____

## SLEEP
- ☐ Snoring
- ☐ Stop breathing/ gasp for air at night
- ☐ Dry mouth/ Sore throat
- ☐ Wake up with headaches
- ☐ Tired during the day/while driving
- ☐ Fall asleep while reading/watching TV
- ☐ Other_____

## DRUG ALLERGIES: Please list ALL medications you are allergic to.

| MEDICATION (including over-the-counter) | Reaction |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |

## CURRENT MEDICATIONS: Please list ALL meds you are currently taking. Include dosage and how often you take each med.

Current Pharmacy: _____ Address: _____ Phone: _____

******Please list any additional medications on a separate sheet of paper******

| MEDICATION (including over-the-counter) | Strength | HOW OFTEN DO YOU TAKE? |
|---|---|---|
| | | |
| | | |
| | | |
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## PREVIOUS MEDICAL ILLNESSES: Please check any illnesses you have had in the past.

******Please list the year the illness was diagnosed beside any checked box*******

- ☐ Anemia / Low Blood
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding from Bowels
- ☐ Bleeding Problems, Type: _____
- ☐ Blood Clot in Leg
- ☐ Blood Clot in Lung
- ☐ Blood Transfusion
- ☐ Cancer, Type: _____
- ☐ Communicable Diseases, Type: _____
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes / High Blood Sugar
- ☐ Emphysema / Chronic Bronchitis
- ☐ Epilepsy / Seizures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Kidney Disease, Type: _____
- ☐ Kidney Stones
- ☐ Liver Disease, Type: _____
- ☐ Prostate Problems
- ☐ Rheumatic Fever
- ☐ Skin Disease, Type: _____
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers in Bowels / Stomach
- ☐ Varicose Veins or Spider Veins
- ☐ Other: _____

## CURRENT SPECIALISTS:

| SPECIALTY | NAME | LOCATION | PHONE # |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

## Females ONLY: Please write N/A on the lines that DO NOT apply to you, or leave blank.

**Are you pregnant or planning to be pregnant soon?** ☐ Yes ☐ No **Currently breast feeding?** ☐ Yes ☐ No

**Number of:** Pregnancies? _____ Miscarriages? _____ Deliveries? _____ Abortions? _____

**Current form of Birth Control:** _____

**Date of most recent:** Pap smear? _____ Abnormal Pap(s)? _____

Mammogram? _____ Abnormal Mammogram(s)? _____

## SURGERY HISTORY:

| SURGERY | DATE | SURGERY | DATE | DETAILS |
|---|---|---|---|---|
| Appendectomy | | Joint Replacement | | Joint: |
| Tonsillectomy | | Joint Scope Surgery | | Joint: |
| Gallbladder | | Abdominal Surgery | | Type: |
| Hysterectomy | | Biopsy | | Type: |
| Vasectomy | | Cataract Surgery | | □ Right □ Left |
| Open Heart Surgery | | Broken Bone Repair | | Bone: |
| Neck Artery Surgery | | Colonoscopy | | □ Normal □ Abnormal |
| Prostate Surgery | | Other | | |
| Back Disc Surgery | | Other | | |

## SOCIAL HISTORY:

♦ **Primary language if not English:** _____

♦ **Current Employment:** ☐ Full-time ☐ Part-time ☐ Not working ☐ Retired ☐ Student **Occupation:** _____

♦ **Marital Status:** _____ ♦ **Number of children:** _____

♦ **Do you have a living will?** ☐ Yes ☐ No

♦ **Religion:** Describe any ethnic, religious or cultural beliefs you have that may/will influence your treatment. _____

_____

## FAMILY HISTORY: Check the box of any disease that has affected your parents, brothers, and/or sisters.

| | Heart Attack | High Blood Pressure | High Cholesterol | Asthma | Tuberculosis | Liver Disease | Kidney Disease | Osteoporosis | Stroke | Epilepsy / Seizure | Bleeding Disorder | Diabetes | Thyroid Disorder | Cancer | Alcohol Abuse | Anxiety/Depression | Glaucoma | Other | Please provide details for any checked boxes |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Father | | | | | | | | | | | | | | | | | | | |
| Mother | | | | | | | | | | | | | | | | | | | |
| Sibling Male/Female | | | | | | | | | | | | | | | | | | | |
| Sibling Male/Female | | | | | | | | | | | | | | | | | | | |
| Paternal Grandfather | | | | | | | | | | | | | | | | | | | |
| Paternal Grandmother | | | | | | | | | | | | | | | | | | | |
| Maternal Grandfather | | | | | | | | | | | | | | | | | | | |
| Maternal Grandmother | | | | | | | | | | | | | | | | | | | |
| Son | | | | | | | | | | | | | | | | | | | |
| Daughter | | | | | | | | | | | | | | | | | | | |
| Other | | | | | | | | | | | | | | | | | | | |

## CURRENT HEALTH HABITS:

| How often do you exercise? | Smoking: | |
|---|---|---|
| ☐ Never ☐ Rarely ☐ Daily | - Have you ever smoked? ☐ Yes ☐ No<br>- Number of Years: _____ | - How many packs currently smoked daily? _____<br>- Use of smokeless tobacco? ☐ Yes ☐ No<br>- Do you currently smoke? ☐ Yes ☐ No |

♦ **Alcohol consumption:** ☐ Rarely ☐ Socially ☐ Never Quantity? _____

## IMMUNIZATIONS: Please list the date of your most recent vaccination

Tetanus: _____ Influenza: _____ Shingles: _____ Pneumovax: _____