Patient Clinical Information Form **Name_____ DOB_____**

Reason for visit:

Medication allergy and reaction:

Current medications:

Past medical history:

Diabetes	◯Y ◯N	**Osteoporosis**	◯Y ◯N	**Blood Clots**	◯Y ◯N
Chest pain	◯Y ◯N	**Asthma/COPD**	◯Y ◯N	**Peripheral Vascular Dis**	◯Y ◯N
High Blood Pressure	◯Y ◯N	**Stroke/CVA/TIA**	◯Y ◯N	**Tuberculosis**	◯Y ◯N
Heart Disease	◯Y ◯N	**Seizures**	◯Y ◯N	**Depression**	◯Y ◯N
Heart Attack	◯Y ◯N	**HIV/AIDS**	◯Y ◯N	**Cogestive Heart Failure**	◯Y ◯N
High Cholesterol	◯Y ◯N	**Hepatitis**	◯Y ◯N	**Thyroid Disease**	◯Y ◯N
Pacemaker	◯Y ◯N	**Stomach Ulcer**	◯Y ◯N	**Others (please list):**	
Headaches	◯Y ◯N	**Liver Disease**	◯Y ◯N		
Kidney Stones	◯Y ◯N	**Heart Palpitations**	◯Y ◯N		
Kidney Disease	◯Y ◯N	**Arthritis**	◯Y ◯N		
Cancer	◯Y ◯N	**Heart Surgery**	◯Y ◯N		

Review of Systems: (Mark all that apply in relation to your chief complaint today)

Constitutional	◯Weight loss ◯Weight gain ◯Fevers ◯Chills ◯Poor appetite ◯Fatigue ◯Insomnia ◯Night Sweats
Eyes	◯Blurry vision ◯Eye pain ◯Eye Discharge ◯Redness ◯Decrease in vision ◯Dry eyes ◯Double vision
ENT	◯Sore throat ◯Hoarseness ◯Ear pain ◯Hearing loss ◯Ear discharge ◯Nose bleeds
Cardiovascular	◯Chest pain ◯Palpitations ◯Rapid heart rate ◯Murmur ◯Poor cirulation ◯Swelling in legs or feet
Respiratory	◯Shortness of breath ◯Cough ◯Coughing up blood ◯Excessive sputum production ◯Wheezing
Gastrointestinal	◯Nausea ◯Vomiting ◯Diarrhea ◯Constipation ◯Blood in stool ◯Frequent heartburn
Genitourinary	◯Urinary frequency ◯Painful/difficult urination ◯Blood in urine ◯Incontinence ◯Retention
Skin	◯Rash ◯Hives ◯Hair loss ◯Sores/ulcers ◯Itching ◯Skin thickening ◯Nail changes ◯Mole changes
Musculoskelital	◯Joint pain ◯Frequent cramps ◯Muscle weakness/aches ◯Bone pain ◯Joint swelling ◯Back pain
Psychiatric	◯Anxiety ◯Depression ◯Alcohol/drug dependence ◯Suicidal thoughts ◯Panic attacks
Endocrine	◯Goiter ◯Heat/cold intolerance ◯Increased thirst ◯Skin pigment change ◯Excessive sweating
Neurological	◯Seizures ◯Tremors ◯Migraines ◯Numbness Dizziness/vertigo ◯Slurred speech ◯Stroke
Hematologic	◯Low blood count ◯Easy bruising ◯Swollen lymph nodes ◯Transfusions ◯Blood clots
Immunilogic	◯Allergic reactions ◯Hay fever/seasonal allergies ◯Frequent infections

Additional Information:

Social History: Marital Status_____Occupation:_____Alcohol: ◯Never ◯Occasional ◯Frequent

Smoking: ◯Never/former smoker ◯Current smoker If yes, how many packs per day?_____

Family History: (Please list any known problems)

Father:_____ Mother:_____ Siblings:_____

For office use below:

All other systems reviewed and negative as relates to chief complaint and document reviewed.

Assistant Initial:_____ Provider Initial:_____