Medical Examination Form

Patient Name:_____ Date of Birth:_____

Medication List (Prescription, Over the counter, Supplement)

Name	Reason	Dosage	Frequency

Allergies:_____

Medical Conditions:_____

Surgeries:_____

Date of last Mammogram:_____ Date of last Pap Smear:_____ Date of last Physical:_____

Date of last Tetanus shot:_____ Last Menstrual Period:_____

Tobacco Use and type(include smokeless):_____Years Used: _____

Packs per day:_____ Former smoker-quit date_____ Ready to quit: Yes or No

Alcohol Use and type:_____ How many drinks per week:_____

Drug Use: Yes or No Type:_____ How often: _____

Exercise: Yes or No Type:_____ How often: _____

Caffeine intake: Yes or No: Type: _____ How often: _____

Family History

	Yes	No	Family Member	Remarks
Anxiety				
Arthritis				
Asthma				
Cancer				
Depression				
Diabetes				
Heart Disease				
High Blood Pressure				
High Cholesterol				
Kidney Disease				
Psychiatric Illness				
Other				

Review of Systems

	Yes	No		Yes	No		Yes	No
Weight loss			Chest pain/tightness/pressure			Nausea/Vomiting		
Fatigue			Irregular Heartbeat/Palpitations			Diarrhea		
Memory loss			Elevated Blood Pressure			Abdominal pain		
Headache			Limb swelling			Anemia		
Vision loss			Excessive thirst			Bleeding disorder		
Decreased Hearing			Excessive urination			Dizziness		
Cough			Bloody stool or hemorrhoids			Pain with urination		
Shortness of Breath			Constipation			Blood in urine		
Wheezing			Heartburn/Indigestion			Joint pain		
Seizure			Numbness/tingling			Anxiety		
Depression			Insomnia			Jaw pain		

Patient Signature:_____ Date:_____