ANNUAL PATIENT MEDICAL INFORMATION

Patient Name:____ **Date of Birth:**_____________

Height: _________ **Weight:** _____________ **Shoe Size:** ________ ☐ **Men's** ☐ **Women's**

Smoker? ☐ No ☐ Yes, how long? _________ How many packs a day? ____________ Quit_______

Vaping? ☐ No ☐ Yes, how long? _____________ How often? ________ Quit__________

Alcohol use? ☐ No ☐ Yes, how often? ☐ Weekly ☐ Occasionally ☐ Rarely

Drug use? ☐ No ☐ Yes, what type? ☐ Marijuana ☐ Illegal Prescription, what type? ________________

☐ Other: ________________________

Have you gotten a flu vaccine this season? ☐ No ☐ Yes, Date: ____________

Have you gotten a pneumonia vaccine within the last 5 years? ☐ No ☐ Yes, Date: ___________

PAST MEDICAL HISTORY: Have you ever **HAD or HAVE** any of the following:

☐ Arthritis ☐ Back Problems ☐ Cancer ☐ Colitis ☐ Depression ☐ Dermatitis ☐ Peptic Ulcer

☐ Asthma ☐ Bleeding Disorder ☐ Heart Disease ☐ Kidney Disease ☐ Lung Disease ☐ HIV+

☐ High Cholesterol ☐ Hepatitis ☐ Venous Disease ☐ Artificial Valves or Joints ☐ Gout

☐ High Blood Pressure ☐ Rheumatoid Arthritis ☐ Osteoarthritis ☐ Circulatory Problems

☐ Pneumonia ☐ Thyroid Disease ☐ Tuberculosis ☐ Diabetes-Type 1 ☐ Diabetes-Type 2

☐ Gallbladder Problems ☐ Neuropathy

☐ Any other medical problems not listed above: _____________________________________

☐ **NONE OF THE ABOVE**

Have you had any **SURGERIES** or been **HOSPITALIZED** since you were seen last? ☐ No ☐ Yes

If yes, please describe: ____

____

MEDICATIONS: Are there are changes in your medications since you were seen last? ☐ No ☐ Yes

☐ **NONE AT THIS TIME**

ALLERGIES: Are there are changes in your medications since you were seen last? ☐ No ☐ Yes

☐ **NO KNOWN DRUG ALLERGIES**

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REVIEW OF SYMPTOMS: Are you **CURRENTLY** experiencing any of the following:

GENERAL: ☐ Chills ☐ Fever ☐ Unexplained Weight Gain ☐Unexplained Weight Loss

EYES: ☐ Eye symptoms

EARS/NOSE/THROAT/MOUTH: ☐ Ear Symptoms ☐ Nasal Symptoms ☐ Throat/Mouth Symptoms

CARDIOVASCULAR: ☐ Chest Pain ☐ Cold Feet ☐ Numbness/Tingling in Feet ☐ Rest Pain
☐ Pain in calf's when walking ☐ Stiffness in joints ☐ Swelling of legs
☐ Swelling of feet ☐ Swelling of ankles ☐ Non-healing ulcer ☐ Vein problems

RESPIRATORY: ☐ Shortness of breath ☐ Cough ☐ Congestion

GI: ☐ Changes in appetite ☐ Constipation ☐ Diarrhea ☐ Indigestion ☐ Nausea ☐ Ulcers ☐ Vomiting

GU: Urinary frequency ☐ Excessive urination ☐ Pain with urination

MUSCULO: ☐ History of falls ☐ Leg cramps ☐ Muscle aches ☐ Tenderness

SKIN: ☐ Skin symptoms ☐ Hair symptoms ☐ Nail symptoms

NEUROLOGIC: ☐ Difficulty with balance ☐ Headache ☐ Lightheadedness ☐ Restless leg syndrome
☐ Stroke

PSYCHIATRIC: ☐ Anxiety ☐ Insomnia ☐ Memory loss ☐ Mood changes

ENDOCRINE: ☐ Dry Skin ☐ Hair loss ☐ Excessive sweating ☐ Excessive thirst ☐ Thyroid problems

HEMA/LYMPH: ☐ Excessive bleeding ☐ Bruising

FAMILY HISTORY: Has any member of your immediate family been treated for the following?

	MOTHER	**FATHER**	**GRANDMOTHER**	**GRANDFATHER**
☐ Arthritis	☐	☐	☐	☐
☐ High Blood Pressure	☐	☐	☐	☐
☐ Cancer	☐	☐	☐	☐
☐ Heart Disease	☐	☐	☐	☐
☐ Diabetes				
Type I	☐	☐	☐	☐
Type II	☐	☐	☐	☐
☐ UNKNOWN	☐	☐	☐	☐