Patient name: _____

Date of birth: _____ Today's date: _____

❑ New Patient ❑ Established Patient

Please describe the reason(s) for your visit today: _____

Do you have any problems you wish to discuss today? _____

Primary Care Doctor: _____ Referred by: _____

If medically necessary / in an emergency, would you accept the use of blood or blood products?
PLEASE CHECK ONE:

- ***Yes, I would accept blood or blood products.***
- ***No, under no circumstances would I accept blood or blood products.***

Important: In order to provide the highest quality of healthcare possible, it is important that we have the following information. Please answer all questions as accurately as possible. If you do not understand the questions, please ask for assistance. Thank you.

Review of Systems: Circle any of the following if you have now or have had *within the past year.*

Const: Weight Gain / Loss
Fever
Fatigue

Eyes: Dry Eyes
Vision Changes

ENT: Earaches
Ringing in Ears
Mouth Sores
Sinus Headaches

Resp: Persistent Cough
Wheezing
Shortness of Breath

CV: Chest Pain
Difficulty Breathing on Exertion
Swelling of Legs
Palpitations of Heart

Neuro: Dizziness
Seizures
Numbness or Tingling
Trouble Walking

Endo: Dry Skin
Abnormal Thirst
Hot / Cold Intolerance

Heme: Frequent Bruises
Cuts That Do Not Heal

GI: Frequent Diarrhea
Bloody Stool
Chronic Nausea / Vomiting
Chronic Constipation
Change in Bowel Habits
Eating Disorder

Urinary: Blood in Urine
Pain or burning with Urination
Frequency of Urination
Incomplete Emptying
Involuntary Loss of Urine with Cough / Strain
Urgency
Frequently Waking up at Night to Urinate

Musc: Muscle Weakness
Back Pain

Skin: Rash
Ulcers / Sores

Breast: Pain
Mass or Lump
Nipple Discharge

Psych: Depression
Panic Attacks
Mood Swings

Other: _____

Pregnancy Information (if applicable):

Total number of pregnancies: _____

Please list your pregnancies below and check the column(s) that apply to each birth. Attach an additional page if necessary.

	Month/Year	Vaginal birth	Cesarean birth	Term	Preterm	Ectopic	Miscarriage / Pregnancy Loss
1.	_____	❑	❑	❑	❑	❑	❑
2.	_____	❑	❑	❑	❑	❑	❑
3.	_____	❑	❑	❑	❑	❑	❑
4.	_____	❑	❑	❑	❑	❑	❑