

| REASON FOR VISIT: ALLERGIES TO MEDICATIONS: PAST MEDICAL HISTORY Y N IF YES, EXPLAIN FAMILY HISTORY Y N RELATIVE RELATIONSHI SEASONAL ALLERGIES ANESTHESIA PROBLEMS ASTHMA BLEEDING DISORDER CANCER CANCER DIABETES ESOPHAGEAL REFLUX HEART DISEASE HEART DISEASE HEART DISEASE HEART DISEASE HEART DISEASE HIGH BLOOD PRESSURE LUNG DISEASE STROKE THYROID DISORDER OTHER MEDICAL PROBLEMS: DID YOU HAVE YOUR FLU SHOT: FOR ADULT PATIENTS Y N FOR PEDIATRIC'S TYPEN WHEN: FOR PEDIATRIC'S STUDENT HOW MANY PACKS PER DAY IF QUIT WHAT YEAR? IS THERE A SMOKER IN THE HOME? DO YOU DRINK ALCOHOL? DRINKS PER WEEK: SIBLINGS: ANESTHESIA PROBLEMS. Y N RELATIVE RELATIONSHI SASTHMA ASSTHMA BLEEDING DISORDER THYROID | |
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| DO MOM DEPTH OFFEED | |
| DO YOU DRINK COFFEE? CUPS PER DAY: | |
| REVIEW OF SYSTEMS Y N PLEASE INDICATE IF YOU HAVE HAD THE FOLLOWING Y N | |
| SHORTNESS OF BREATH COUGH | |
| CHEST PAIN PALPITATIONS | |
| BLURRED VISION WATERY/ITCHY EYES | |
| ABDOMINAL PAIN HEARTBURN | |
| FATIGUE HEADACHE | |
| CHILLS NIGHT SWEATS | |
| WEIGHT LOSS WEIGHT GAIN | |
| BLEEDING PROBLEMS SWOLLEN GLANDS | |
| JOINT ACHES BACK PAIN | |
| PAINFUL URINATION FREQUENT URINATION | |
| RASH/HIVES ITCHING DEPRESSION ANXIETY/PANIC DISORDER | |
| DEFRESSION ANAIETI/PANIC DISURDER | |
| HAVE YOU HAD 2 OR MORE FALLS IN THE PAST YEAR? YES NO | |
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| HAVE YOU HAD ANY FALLS IN THE PAST YEAR RESULTING IN INJURY? YES NO | |

**** PLEASE LIST ANY **OPERATIONS**, **HOSPITALIZATIONS** YOU HAVE EVER HAD (INCLUDE TONSILS & ADENOIDS), AND THE YEAR:

**** PLEASE LIST **ANY CURRENT MEDICATIONS** (INCLUDE AMOUNTS, TIMES PER DAY). PLEASE INCLUDE ASPIRIN, ANTACIDS, VITAMINS, BIRTH CONTROL, HERBAL SUPPLEMENTS, HORMOME REPLACEMENT, NASAL SPRAYS, and COLD/SINUS/ALLERGY MEDICATIONS: