



Patient Medical History & Review of Symptoms Form

Date Form Completed: _____

Patient Name: _____ Date of Birth: _____

Please mark "X" in the box below, if you have any of the conditions or symptoms listed. Explain any box that you mark on page 2.

GASTROINTESTINAL/GENITOURINARY

- ☐ Poor Appetite
- ☐ Abdominal Pain
- ☐ Indigestion
- ☐ Trouble Swallowing
- ☐ Painful Urination
- ☐ Trouble Starting Urination
- ☐ Blood in Urine
- ☐ Loss of Bladder Control
- ☐ Loss of Bowel Control
- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Ulcer
- ☐ Liver Disease
- ☐ Enlarged Prostate

CARDIOVASCULAR

- ☐ Chest Pain
- ☐ Diaphoresis
- ☐ Poor Circulation/Swelling
- ☐ Irregular Heart Beat
- ☐ High Blood Pressure/Hypertension
- ☐ Heart Attack
- ☐ Pacemaker
- ☐ Heart Stents
- ☐ Open Heart Surgery
- ☐ Rheumatic Fever
- ☐ Heart Disease

PULMONARY/LUNGS

- ☐ Shortness of Breath
- ☐ Persistent Cough
- ☐ Coughing up Blood
- ☐ Wheezing
- ☐ CPAP Use
- ☐ Oxygen Use
- ☐ COPD
- ☐ Emphysema
- ☐ Asthma
- ☐ TB
- ☐ Sleep Apnea

SKIN

- ☐ Itching
- ☐ Rash
- ☐ Easy Bruising
- ☐ Skin Tears Easily
- ☐ Skin Conditions
- ☐ Eczema

MUSCLE/JOINT/BONE

- ☐ Back Pain
- ☐ Leg Pain
- ☐ Neck Pain
- ☐ Arm Pain
- ☐ Joint Pain
- ☐ Joint Swelling
- ☐ Weakness Arms/Legs
- ☐ Arthritis
- ☐ Gout
- ☐ Osteoporosis

NEUROLOGIC

- ☐ Fainting
- ☐ Dizziness
- ☐ Slurred Speech
- ☐ Loss of Consciousness
- ☐ Headache
- ☐ Memory Loss
- ☐ Depression
- ☐ Anxiety
- ☐ Alzheimer's Disease
- ☐ Parkinson Disease
- ☐ Psychiatric Illness
- ☐ Claustrophobic
- ☐ Fibromyalgia
- ☐ TIA or Mini Stroke(s)
- ☐ Stroke

EYES/EARS/NOSE/THROAT

- ☐ Blurred Vision
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nose Bleeds
- ☐ Sinus Problems
- ☐ Cataracts
- ☐ Glaucoma
- ☐ Contacts/Glasses
- ☐ Hearing Aids
- ☐ Vocal Cord Damage
- ☐ Throat Surgeries
- ☐ Other Throat Conditions

ENDOCRINE

- ☐ Excessive Thirst
- ☐ Excessive Sweating
- ☐ Excessive Hot
- ☐ Excessive Cold
- ☐ Diabetic Type 1
- ☐ Diabetic Type 2
- ☐ Hyperthyroid
- ☐ Hypothyroid
- ☐ Pituitary Tumor

Patient Medical History & Review of Symptoms Form - Page 2

Patient Name: _____

Please mark "X" in the box below, if you have any of the conditions or symptoms listed. Explain any box that you mark below.

HEMATOLOGIC/LYMPHATIC

- ☐ Bleed Easily
- ☐ Clot Easily
- ☐ Abnormal Blood Cells
- ☐ Lymph Node Swelling
- ☐ History of Anemia
- ☐ History of Blood Clots or DVT
- ☐ History of Pulmonary Embolism or PE
- ☐ Any Blood Condition or Bleeding Disorder

GENERAL

- ☐ History of any Type of Cancer
- ☐ History of MRSA
- ☐ History of Chronic Infection
- ☐ Genetic Disorders
- ☐ Immunodeficiency
- ☐ Trouble with Anesthesia

Please use the space below to explain any of the above areas that you marked on page 1 or page 2.

Please list all previous surgeries with date and name of surgeon, if known.

Vaccinations

Please list most recent vaccination dates or not applicable:

Flu Vaccination _____ Pneumonia Vaccination _____ Tetanus Vaccination _____



Patient Medication and Allergy Form

Date Form Completed: _____
Patient Name: _____ Date of Birth: _____
Address: _____
Home Phone: _____ Cell Phone: _____
Pharmacy Phone Number: _____ Pharmacy Address: _____

List all drug allergies and reactions that occur: (Example: Penicillin - rash, vomiting, trouble breathing)

1 _____
2 _____
3 _____
4 _____
5 _____
6 _____

Are you allergic to latex? ☐ No ☐ Yes If yes, what reaction do you have? _____

Are you allergic to tape ? ☐ No ☐ Yes If yes, what type(s)? _____

List Food or Environmental Allergies: _____

List all medications you are taking. Please include all prescription, over-the-counter medications, vitamins and any other natural supplements.

Name and Dose of Medication(s) (Example: Aspirin, 81 mg.)	Number of times you take it and why. (Example: 1 per day - Blood thinner)
1 _____	_____
2 _____	_____
3 _____	_____
4 _____	_____
5 _____	_____
6 _____	_____
7 _____	_____
8 _____	_____
9 _____	_____
10 _____	_____
11 _____	_____
12 _____	_____
13 _____	_____
14 _____	_____
15 _____	_____
16 _____	_____
17 _____	_____
18 _____	_____

ISG MD's Signature: _____ Date: _____
after review with patient



Patient Social History Form

Date Form Completed: _____

Patient Name: _____ Date of Birth: _____

Tobacco Use ? ☐ No ☐ Yes If yes, how many packs per week/day? _____

Alcohol Use ? ☐ No ☐ Yes

☐ Rare - less than 1 drink/month
☐ Occasionally - 1-4 drinks/month
☐ Socially - 1-2 drinks/week
☐ Occasionally - 3-5 drinks/week
☐ Frequently - 5 or more drinks/week

Recreational Drug Use ☐ No ☐ Yes If yes, please specify

Types: _____

Use per week: _____

Educational Level (Grade Completed) ☐ Grade School ☐ High School/GED ☐ College ☐ Graduate Level

Exercise Level ☐ Never ☐ Rarely ☐ Weekly ☐ Daily

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Number of Children and Ages _____

Do you live ☐ Alone ☐ With Someone ☐ Assisted Living: ☐ Nursing Home

Nationality _____

Primary Language _____

