303 S. Moorpark Rd, Thousand Oaks, CA 91361 805-497-7508 Fax: 495-6834

Who will be accompanying you on the day of your visit? Please provide name and relationship

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What are we seeing you for today? For multiple problems list by number in order of importance

Problem:

Describe it, location, associated symptoms:

When did your problem first begin? Is it overall better or worse?

How long does it last?

How frequent is it?

What makes it better?

What makes it worse?

Please list your symptoms on a scale from 1-10 (10 being worst)	

List medications, herbs, vitamins and over the counter medications you are taking:

Name:___________________________ **DOB:____________________** **(Office Use) Acct:___________________**

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List allergies to medications and the reaction experienced:

Past Medical History. Please check what applies or add pertinent history and give details:

1) Constitution: ☐Fatigue: ☐ Fibromyalgia:

2) Eyes: ☐Cataracts: ☐Glaucoma:

3) Ears,Nose,Throat: ☐Sinus: or ☐Other Infections:

4) Pulmonary: ☐Allergies: ☐Asthma: ☐Coccidiomycosis: ☐COPD:
☐Emphysema: ☐Cystic Fibrosis: ☐Exposure to toxic chemicals: ☐Asbestos :
☐Fibrosis: ☐Lung Cancer: ☐Lung Surgery: ☐ Pneumonia:
☐Sarcoid: ☐Tuberculosis:

5) Cardiovascular: ☐Heart attack: ☐Heart murmur: ☐Heart bypass operation:
☐Heart valve surgery: ☐High cholesterol: ☐Hypertension:
☐Pacemaker:

6) Gastrointestinal: ☐Gallstones: ☐GERD: ☐Hepatitis: ☐ Jaundice:
☐Lactose Intolerance: ☐Ulcers:

7) Renal: ☐Kidney Infection: ☐Kidney Stones: ☐Urinary Infection :

8) Genitourinary: ☐Prostate Cancer: ☐Prostate Infection: ☐Impotence:

9) Musculoskeletal: ☐Sciatica: ☐Scoliosis:

10) Hemo/Oncology: ☐Anemia: ☐Cancer: ☐Leukemia:

11) Endocrine: ☐Diabetes: ☐Hyperthyroid: ☐Hypothyroid:
☐Gout:

12) Neurological: ☐Alzhiemers: ☐Dementia: ☐Headaches: ☐Migraine:
☐Multiple Sclerosis: ☐Polio: ☐Seizure, Stroke:

13) Psychological: ☐Depression: ☐ Anxiety: ☐Suicide Attempts:

14) Dermatological: ☐Eczema: ☐Rashes: ☐Skin Cancer:

15) Immunological: ☐Allergy:

16) Gynecological: ☐Menopause: ☐Menorrhagia:

17) Obstetrical: Pregnancy total_____ Miscarriage total _______ Other:

Social History. Please check what applies and give details:

☐Single: ☐Married: ☐Divorced: ☐Widowed: ☐Other:

What is your spouse's name?

What is your **occupation**? Company you work for?

What city do you **live** in?

What city do you **work** in?

Where were you born, year?

Who referred you here?

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Do you have pets, cats, birds, dogs, horses, reptiles, etc?
How much alcohol per day? What type?
How much coffee per day?
Do you smoke or chew tobacco?
How much? For how long? When did you quit?
Do you exercise regularly? Describe
Where have you travelled outside the US and what year?
Describe your regular diet, such as: ☐fast food, ☐vegetarian, ☐fish, ☐dairy, ☐soda, ☐red meat

Family History	**Alive**	**Deceased**	**Age**	**Medical Problems**
Father				
Mother				
Brothers				
Sisters				

Illnesses which run in your family: Check box and state who
Pulmonary: ☐Asthma: ☐ COPD: ☐Cystic Fibrosis: ☐Emphysema: ☐Tuberculosis:
Cardiovascular: ☐ Heart Disease: ☐Hypertension: ☐Stroke:
Gastrointestinal: ☐Hepatitis:
Renal: ☐Kidney Failure:
Musculoskeletal: ☐Arthritis:
Hemo/Oncology: ☐Bleeding Abnormalities: ☐Blood Clots: ☐Cancer:
Endocrine: ☐Diabetes:
Neurological: ☐Alzheimers : ☐ Dementia: ☐ Multiple Sclerosis:
Psychological: ☐Depression: ☐ Anxiety: ☐ Suicide Attempts:

REVIEW OF SYSTEMS:

Please check those symptoms you have. State the severity and duration**.** Example: COUGH ***mild 3 days***

1) Constitution: ☐Appetite Loss: ☐Awakening Frequently: ☐FATIGUE: ☐FEVER: ☐INSOMNIA: ☐Sleepy all the time: ☐Weight Gain: ☐ Weight Loss:

2) Eyes: ☐Eye Floaters: ☐Vision Blurred: ☐Vision Double:

3) Ears,Nose,Throat: ☐Ears Ringing: ☐DIZZINESS: ☐Hearing Decreased: ☐Nasal Discharge: ☐NOSE BLEEDS: ☐Sinus Congestion: ☐SNORING: ☐Swallowing Difficulty: ☐Throat Sore:

4) Respiratory: ☐Blue Fingernails: ☐Blue Lips: ☐BREATHLESS: ☐Breathless while lying flat: ☐COUGH: ☐Coughing Up Blood: ☐Leg Swelling: ☐Night Sweats: ☐SPUTUM: ☐WHEEZING:

5) Cardiovascular: ☐Chest Pain: ☐Leg Cramps When Walking: ☐Light Headed : ☐FAINTING: ☐PALPITATIONS:

REVIEW OF SYSTEMS CONTINUED ON NEXT PAGE

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REVIEW OF SYSTEMS CONTINUED:

6) Gastrointestinal: ☐Abdominal Pain: ☐Acid in Throat: ☐CONSTIPATION: ☐DIARRHEA: ☐Heartburn: ☐INDIGESTION: ☐NAUSEA : ☐VOMITING: ☐Stool Black: ☐Bloody Stools:

8) Genitourinary: ☐Erectile Dysfunction: ☐Urinate Frequently: ☐Urination Painful:

9) Musculoskeletal: ☐Back Pain: ☐Body Pain: ☐Joint Pain: ☐Muscle Aches:

10) Hemo/Oncology: ☐Bruise Easy ☐Lymph Node Swelling

11) Endocrine: ☐Cold Frequently ☐Hot Flashes ☐Hot Frequently ☐MENOPAUSE ☐Hungry All The Time ☐Thirsty All The Time

12)Neurologic: ☐HEADACHES ☐Loss Of Balance ☐Memory Loss ☐NUMBNESS ☐WEAKNESS ☐Vision Changes

13)Psychological: ☐Cry often: ☐DEPRESSED: ☐NERVOUS: ☐Sad All The Time: ☐Suicide Attempts Or Thoughts: ☐Unusual Thoughts:

14)Skin: ☐Change In Mole: ☐Hair Loss: ☐ITCHING: ☐RASH: ☐Toenails Abnormal:

15)Allergy: ☐ Eyes Itchy: ☐SNEEZING:

16)Gynecological: ☐Breast Problems: ☐Menstrual Flow Heavy:

Are there any other issues that you would like to discuss?

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Patient Signature ________________________

Name:__________________________ **DOB:**_____________ **(Office Use) Acct:**__________________