PFSH

Patient Name: Referring Physician: DOB:

Are you allergic to any medications or food (shellfish)? NO YES Please list:

Medical History: Check ALL that apply.

	Yes	No		Yes	No		Yes	No
Cataracts	☐	☐	GERD	☐	☐	Bipolar Disorder	☐	☐
Detached Retina	☐	☐	Gallbladder	☐	☐	Depression	☐	☐
Angina/Chest Pain	☐	☐	Stomach Ulcer	☐	☐	Hyperlipidemia	☐	☐
Blood Clot/DVT	☐	☐	Incontinence	☐	☐	Hypothyroidism	☐	☐
Hypertension	☐	☐	Hernia	☐	☐	Type I DM	☐	☐
Heart Attack	☐	☐	Kidney Stones	☐	☐	Type 2 DM	☐	☐
Pacemaker	☐	☐	UTIs	☐	☐	Anemia	☐	☐
Stroke/CVA	☐	☐	Osteoporosis	☐	☐	Clotting Disorder	☐	☐
Peripheral Vascular	☐	☐	RA	☐	☐	Seizures	☐	☐
Asthma	☐	☐	Osteoarthritis	☐	☐	TIA	☐	☐
COPD	☐	☐	Gout	☐	☐	**Surgical History (Include year):**		
Cancer	☐	☐	Psoriasis	☐	☐			

Medication List with Dosages:

ROS	(-)	Please Check all **CURRENT** positive findings
Constitutional		☐ Weight Loss ☐ Weight Gain ☐ Chills ☐ Fever ☐ Night Sweats ☐ Fatigue ☐ Daytime Drowsiness
Eyes		☐ Vision Changes ☐ Headache ☐ Eye Pain ☐ Double Vision ☐ Cataracts
Cardiovascular		☐ Chest Pain ☐ Palpitations ☐ Murmur ☐ Difficulty Breathing ☐ Leg Pain ☐ Swelling of Legs ☐ Varicose Veins
Respiratory		☐ Asthma ☐ Coughing up blood ☐ Wheezing ☐ Shortness of Breath
Gastrointestinal		☐ Abdominal Pain ☐ Black/Tarry Stools ☐ Blood in Stools ☐ Diarrhea/Constipation ☐ Difficulty Swallowing ☐ Indigestion / Heartburn ☐ Cramping ☐ Nausea/Vomiting
Female Reprod.		☐ Breast Lumps/Pain ☐ Burning Urination ☐ Cramps ☐ Frequent Urination ☐ Hormone Therapy ☐ Irregular Menstruation ☐ Urine Retention ☐ Vaginal Bleeding/Discharge
Male Reprod.		☐ Burning Urination ☐ Erectile Dysfunction ☐ Frequent Urination ☐ Hesitancy or Dribbling ☐ Prostate Problems ☐ Urine Retention
Neurological		☐ Dizziness ☐ Facial Weakness ☐ Headaches ☐ Limb Weakness ☐ Loss of Conscious ☐ Loss of Memory ☐ Numbness ☐ Stroke ☐ Unsteadiness of Gait
Musculoskeletal		☐ Neck Pain ☐ Shoulder Pain ☐ Back Pain ☐ Hip. Pain ☐ Knee Pain ☐ Frequent Leg Cramps ☐ Muscle Weakness ☐ Foot Pain ☐ Joint Swelling (List Joint):
Hem/Lymphatic		☐ Anemia ☐ Prolonged Bleeding ☐ Blood Clots ☐ Easy Bruising ☐ Fatigue ☐ Lymph Node Swollen
Endocrine		☐ Diabetes ☐ Heat / Cold Intolerance ☐ Excess Thirst ☐ Incr. Appetite w/out Wt Gain ☐ Frequent Urination ☐ Goiter ☐ Hair Loss
Psychiatric		☐ Anxiety ☐ Depression ☐ Mood Changes ☐ Bipolar Disorder ☐ Suicidal Thoughts ☐ Insomnia ☐ Memory Loss

Social History: Marital Status: ___________________________ Occupation (or most recent job held) __________________________

Non-Smoker (never smoked) ☐ Ex-Smoker☐ Current Smoker☐ (# packs/______day)

Alcohol Consumption: Never ☐ Occasional☐ (#Drinks_____/ week) Frequent ☐ (#Drinks_____/day)

Additional Information: Use this space to provide any additional information which may be important to your health care.

_______________________________________ ____

Signature of Reviewing Physician Date Signature of Patient Date