PATIENT PROBLEM LIST			
PATIENT NAME:	DATE OF BIRTH:	AGE:	DATE:

What is the reason for your visit? ______________________________________Were you referred to our office? Yes___No___

If yes, by whom?____Physician's Phone Number:_________________

Please √ if diagnosed with any of the following:

___Allergies
___Acne
___Anemia
___Arthritis
___Asthma/wheezing
___Back Pain
___Bleeding Disorders
___Blood Transfusions
___Bone Fractures/joint injuries
___Cancer
___Dementia/memory loss
___Dental/oral disease
___Diabetes
___Ear Problems/hearing loss
___Eye Problems/poor vision
___Foot problems
___Gallbladder Disease
___Gout
___Headaches/migraines
___Heart burn/acid reflux
___Heart Disease
___Heart Rhythm Disorder
___Hemorrhoids/Rectal Pain/Bleeding
___Hepatitis
___High Blood Pressure
___High Cholesterol
___Kidney Disease/Stones
___Liver Disease
___Lung Disease
___Menstrual Problems
___Varicose Veins
___Anxiety/Depression
___Prostate Disorder
___Skins Disease
___Stroke
___Thyroid Disease (Hyper/Hypo)

SURGICAL HISTORY (Please list the dates and type of past surgeries)

Type of Surgery	Date of Surgery

MEDICATIONS: (Please list all medications you use; prescription and non-prescription included dosing and how often you take it)

MEDICATION	DOSAGE AND FREQUENCY TAKEN	MEDICATION	DOSAGE AND FREQUENCEY TAKEN
1.		4.	
2.		5.	
3.		6.	

DRUG ALLERGIES: ___YES ___NO If yes, please list:____
DO YOU SMOKE: ___YES___NO If you have quit smoking, how long ago? ____________
IF YES, how many packs per day?_________ or How many cigarette's per day?___________
ALCOHOL: (please check one) Rarely □ Socially □ Everyday □ ___Never

FAMILY HISTORY: (Family history of any type of cancer)

PROVIDER _________________

01/10/2018