



Patient Name \_\_\_\_\_

Do you have:

Drug Allergies  Yes \_\_\_\_\_  No  
Food Allergies  Yes \_\_\_\_\_  No

Are you currently experiencing problems with any of the following? (If Yes, please specify on line)

Sudden weight gain or loss  Yes  No \_\_\_\_\_  
Heart  Yes  No \_\_\_\_\_  
(Example: chest pain, angina, irregular heart beat)  
Respiratory  Yes  No \_\_\_\_\_  
(Example: coughing, wheezing, asthma)  
Ear/Nose/Throat  Yes  No \_\_\_\_\_  
(Example: sore throat, sinus problem, earache)  
Gastrointestinal  Yes  No \_\_\_\_\_  
(Example: abdominal pain, vomiting, heartburn)  
Urinary  Yes  No \_\_\_\_\_  
(Example: pain when urinating, blood in urine)  
Hematologic/Lymphatic  Yes  No \_\_\_\_\_  
(Example: blood disorders, bruising easily, enlarged glands)  
Endocrine  Yes  No \_\_\_\_\_  
(Example: diabetes, thyroid problems)  
Integumentary  Yes  No \_\_\_\_\_  
(Example: rashes, dry skin)  
Musculoskeletal  Yes  No \_\_\_\_\_  
(Example: joint pain, stiffness or swelling)  
Neurological  Yes  No \_\_\_\_\_  
(Example: numbness, headache, seizures)  
Psychiatric  Yes  No \_\_\_\_\_  
(Example: depression, anxiety, insomnia)  
Allergic/Immunologic  Yes  No \_\_\_\_\_  
(Example: seasonal allergies)

I have accurately answered all questions on this form to the best of my ability. I have been offered a copy of Dr. Smrkovski's privacy policies (HIPAA). I also understand that I am financially responsible for my charges if my insurance does not cover the costs of my exam.

\_\_\_\_\_  
Patient Signature (or Parent/Guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

All previous medical history remains accurate. There have been no changes.

Patient Signature:

Date:

Physician Signature:

Date:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_