

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, **hypertension**, 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, **cholesterol**)
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:

