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
____Mental Disease-anxiety/depression
____Prostate Disorder
____Skin Disease (sores, ulcers)
____Sleep Problems (apnea)
____Stroke
____Thyroid Disease (Hyper or hypo)
Other: ___________________
____

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) including dose and how often you take it)

Medication	Dosage and Frequency Taken	Medication Name	Dosage and Frequency Taken
1.		4.	
2.		5.	
3.		6.	

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

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 day? ______________ **or How many cigarettes per day?** ______________

ALCOHOL: (please check one) ☐ **Rarely** ☐ **Socially** ☐ **Everyday** **Never**