Patient Medical History (ROS)

Name:_____ Age:_____ Date:_____
Reason For Appointment:_____
Primary Doctor:_____ Who Referred You:_____
Height:_____Weight:_____
If you are age 65 or over, do you have an Advance Care Plan (living will)? Yes No
Do you use any tobacco products? Yes No _____
Have you smoked 100 cigarettes in your lifetime? Yes No CURRENT FORMER NEVER

Do you drink alcohol?	Yes	No	How much? _____	How often?_____
Do you use recreational drugs?	Yes	No	How much? _____	How often?_____
Do you take aspirin?	Yes	No	How much? _____	How often? _____
Are you pregnant?	Yes	No		
Do you experience any dizziness?	Yes	No		
Have you had any falls in the last year?	Yes	No		

Do you have any of the following medical problems? If yes, please explain.

Heart Disease	Y	N	High Blood Pressure	Y	N
Diabetes	Y	N	Thyroid Problems	Y	N
High Cholesterol	Y	N	Rheumatic Fever	Y	N
Heart Murmurs	Y	N	Stomach Problems	Y	N
Liver Problems	Y	N	Respiratory Problems	Y	N
Arthritis	Y	N	Seizures or Epilepsy	Y	N
Blood Disorders	Y	N	Cancer	Y	N
Hepatitis	Y	N	Infectious Disease	Y	N
If yes to any of above please explain:			Other:_____		

_____
_____

Do you have any of the following symptoms now? (Choose all that apply)

Shortness of Breath_____	Weight Loss_____	Fatigue_____
Visual Disturbance_____	Hearing Loss_____	Cough_____
Nasal Congestion_____	Sore Throat_____	Fever_____
Seasonal Allergies_____	Chest Pain_____	Weakness_____
Abdominal Pain_____	Pain on Urination_____	Numbness_____
Muscle Joint Pain_____	Hoarseness_____	Rash_____

Patient Signature:_____ Date:_____

Provider Signature:_____ Date:_____

*****PLEASE SEE REVERSE SIDE *****

PLEASE ANSWER *ALL* QUESTIONS

Patient Medical History

Name:_____ Age:_____ Date:_____

Pharmacy:_____ Mail-in Pharmacy:_____

Please list all medications including vitamins:

Medication: Dose: Per Day:

Are you allergic to any medications? _____

Any previous surgeries?_____

Any illnesses run in the family?_____

Have you had any recent labs, CT, MRI, XRAY or ultrasound done? (if so please list study and where it was performed):_____

Patient Signature:_____ Date:_____

Provider Signature:_____ Date:_____