ROOM #

Name: _____

Primary care doctor:_____

HT: _____WT: _____ BP: _____ [**R** or **L**] handed

Please circle if you have had any of theses symptoms below in the last 12 months.

Dizziness - Blackouts – Fall – Balance issues

Circle martial status below and write number of children.

[Married / Divorced / Widow / Single] **#of Children:** _____

Allergic to	Reaction

Job status: Full time / Part time / Disabled / Retired **Tobacco use:** Former/ Y / N **Alcohol use:** Y/ N

Reason for todays visit:_____

Nurse to write here: _____

_____

_____

_____

Medications:

Pharmacy(with location):_____

Name of medication: ↓	Mg. ↓	How many times per day? ↓			
1.			7.		
2.			8.		
3.			9.		
4.			10.		
5.			11.		
6.			12.		

Medical History:

Surgeries:

Family History:

- _____
- _____
- _____
- _____
- _____
- _____

Scans:(Any scans of problem area? Where and when?)

_____

Labs:(Most recent labs. Where and when?)

_____