



DATE: \_\_\_\_\_

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Sex (circle one): M F

Your Physician (circle one): Dr. Chow Dr. Doeden Dr. Laedtke Dr. Leebaw Dr. Mattison Dr. Ruegemer

Primary Care Physician \_\_\_\_\_ Tel. Phone \_\_\_\_\_

**REASON FOR VISIT:**

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

**PAST MEDICAL HISTORY:**

- Illnesses:

\_\_\_\_\_

- Surgeries:

\_\_\_\_\_

- Hospitalizations:

\_\_\_\_\_

**CURRENT MEDICATIONS AND DOSAGE:**

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

**ALLERGIES OR DRUG SENSITIVITY (Specify name of drug and reaction):**

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

**SOCIAL HISTORY:**

Marital Status (Circle One): Single Married Divorced Widowed Partner

Number of Children: \_\_\_\_\_

**HABITS:**

- Smoking: Y / N Packs Per Day: \_\_\_\_\_ Approx. Years/Months Spent Smoking: \_\_\_\_\_

- Alcohol: Y / N Number of drinks per day: \_\_\_\_\_

- Caffeine: Y / N Coffee/tea cups per day: \_\_\_\_\_ Sodas Per Day: \_\_\_\_\_

- Exercise: Y / N Describe: \_\_\_\_\_



**FAMILY HISTORY** (Specify age, living/deceased, pertinent medical history):

- Mother: \_\_\_\_\_  
\_\_\_\_\_

- Father: \_\_\_\_\_  
\_\_\_\_\_

- Siblings: \_\_\_\_\_  
\_\_\_\_\_

**FAMILY DISEASES** (circle one):

Hypertension    Diabetes    Thyroid    Heart    Cancer    Kidney Stones    Stroke    Arthritis    Ulcer

Or, write in Other: \_\_\_\_\_

Explain who has/had the above disease and how they are related to you: \_\_\_\_\_

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

Signature: \_\_\_\_\_ Date: \_\_\_\_\_



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

EYES: \_\_\_\_\_  
\_\_\_\_\_

RESPIRATORY: \_\_\_\_\_  
\_\_\_\_\_

CARDIOVASCULAR: \_\_\_\_\_  
\_\_\_\_\_

GASTROINTESTINAL: \_\_\_\_\_  
\_\_\_\_\_

URINARY: \_\_\_\_\_  
\_\_\_\_\_

MUSCULOSKELETAL: \_\_\_\_\_  
\_\_\_\_\_

NEUROLOGICAL: \_\_\_\_\_  
\_\_\_\_\_

PSYCHIATRIC: \_\_\_\_\_  
\_\_\_\_\_

ENDOCRINOLOGICAL: \_\_\_\_\_

- Hypothalamic/Pituitary: \_\_\_\_\_

- Thyroid: \_\_\_\_\_

- Parathyroid: \_\_\_\_\_

- Pancreas: \_\_\_\_\_

- Adrenal: \_\_\_\_\_

- Gonadal: \_\_\_\_\_

- Menstrual History: \_\_\_\_\_

ADDITIONAL DATA:

Signature: \_\_\_\_\_

Date: \_\_\_\_\_