Medications:____

____

____

Allergies: ___ Penicillin ___ Sulfa ___ Latex ___Metal ___Shellfish ___ Iodine ___ Adhesive tape

___ Codeine ___ Anesthetic Other:____

Social History: How frequently do you drink beer, wine, and/or liquor?______________ How much?_____

Do you smoke?________ How many packs/cigars a day?_____________ How many years?_____________

Do you take any illicit drugs?____

Family History: List any family health problems? (Diabetes, Heart disease, Cancer, Foot problems?)

____

____

Primary Care Physician:____________________________________ Date Last Seen:________________

Review of Systems: Have you experienced any of these symptoms over the last few days?

General-
- □ Weight loss or gain
- □ Fatigue
- □ Fever or chills
- □ Weakness
- □ Trouble sleeping

Endocrine-
- □ Heat or cold intolerance
- □ Sweating
- □ Excessive Thirst

Psychiatric-
- □ Nervousness
- □ Depression
- □ Memory loss
- □ Stress

Head-
- □ Headache
- □ Head injury

Ears-
- □ Decreased hearing
- □ Ringing in ears
- □ Ear ache

Skin-
- □ Rash
- □ Lump
- □ Itching
- □ Dryness
- □ Color changes
- □ Hair and nail changes

Respiratory-
- □ Cough
- □ Sputum
- □ Shortness of breath
- □ Wheezing
- □ Difficulty breathing

Neck-
- □ Lumps
- □ Swollen glands
- □ Pain
- □ Stiffness

Nose-
- □ Stuffiness
- □ Discharge
- □ Itching
- □ Nosebleeds

Gastrointestinal-
- □ Heartburn
- □ Change in appetite
- □ Nausea
- □ Constipation
- □ Diarrhea

Hematologic-
- □ Ease of bruising
- □ Ease of bleeding

Cardiovascular-
- □ Chest pain or discomfort
- □ Tightness
- □ Palpitations

Vascular-
- □ Calf pain with walking
- □ Leg Cramping
- □ Swelling in the legs

Musculoskeletal-
- □ Muscle or joint pain
- □ Stiffness
- □ Back pain
- □ Redness of joints
- □ Swelling of joints

Eyes-
- □ Glasses/Contacts
- □ Blurred vision

Throat-
- □ Bleeding
- □ Dentures
- □ Sore tongue
- □ Dry mouth
- □ Sore throat
- □ Hoarseness

Neurologic-
- □ Dizziness
- □ Fainting
- □ Seizures
- □ Numbness
- □ Tingling
- □ Tremor

Urinary-
- □ Frequency
- □ Urgency
- □ Blood in urine
- □ Incontinence

"I certify that the above information is true and correct to the best of my knowledge. I give my permission to the doctor to administer and perform such procedures as may be deemed necessary in the diagnosis and/or treatment of my feed and/or ankles."

SIGNATURE: ____ DATE:___________________