

11685 Alpharetta Hwy. Suite 270 Roswell, GA 30076 (p) 770-619-5100 (f) 404-250-8067

Patient Name:						
Patient Date o	f Birth:		Da	nte:		
What problem	can we help wi	ith today?				
			PAST MEDICAL HISTORY			
□ NO MEDIC	CAL PROBLEMS	3				
Problem Type/Comment		Problem	Type/Comment			
☐ Acid Reflux/GERD			☐ Heart Disease			
☐ Anemia			☐ Hepatitis C			
☐ Anxiety			☐ HIV			
☐ Asthma			☐ High Cholester	rol		
☐ Bleeding [Disorder		☐ High Blood Pre	essure		
☐ Cancer			☐ Kidney Disease	е		
□ COPD			☐ Liver Disease			
☐ Depression			☐ Migraines			
☐ Diabetes			☐ Sleep Apnea			
☐ Hayfever ((Allergies)		☐ Thyroid Diseas	Se		
Other						
			PAST SURGICAL HISTORY			
☐ NO PREVI	OUS SURGERIE	S				
Year	Type Hospital/Doctor					
			HOSPITALIZATIONS			
□ NO PREVI	OUS HOSPITAL	IZATIONS				
Year	Туре			Hospital/Doctor		

FAMILY HISTORY													
			Mother	Father	Sibling	Other				Mother	Father	Sibling	Other
Allergies							☐ High Blood Pressure						
☐ Asthma							☐ Migraines						
☐ Bleeding Disorder							☐ Seizures						
☐ Cancer:							☐ Stroke						
☐ Depression	n/Anxiety						☐ Thyroid Problems						
☐ Diabetes							☐ Other:						
☐ Heart Dise	ase												
				!		!					,		
	PRES	CRIBED DRU	JGS, O	VER-T	HE-C	DUNTE	R DRUGS, HERBALS, AN	ID SUPPLEME	NTS				
Medication Na	ame		Strength Frequency Ta					ıken					
				MEDI	ATIO	L AND	FOOD ALL EDOIEG						
	□ No Mod	instina Allaw		MEDIC	AHUI		FOOD ALLERGIES	ladina (Obalif	iala) Allaway				
■ No Medication Alle Medication/Food Type of Rea							atex Allergy		Type of Reaction				
Wedication/FC	Medication/Food 1		eaction			\dashv	Wedication/1 ood		Type of Neaction				
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		<u> </u>											
					SO	CIAL	HISTORY						
Occupation	What do/did you do for work? Are you retired? ☐ Yes ☐ No						No						
	Do you drink alcohol?	what kind(s)?		-									
Alcohol	Do you drink alcohol?							out your drinki	ng? 🗌 Yes	: _ N	lo		
	Do/did you use tobacco? ☐ Yes ☐ No Secondhand smoke exposure? ☐ Yes ☐ No												
Tobacco	Cigarettes – packs/day: Number of years: Year quit:												
Other	Do you currently use recreational or street drugs? Yes No												

	CURRENT SYMPTOMS (PLEASE	CIRCLE) OR 🗆 NO SYMP	TOMS
Constitutional/General	Nipple Discharge	Indigestion	Endocrine
Fatigue	Cardiovascular	Genitourinary	Heat Intolerance
Fever	Chest Pain	Burning with Urination	Cold Intolerance
Chills	Fainting	Blood in Urine	Excessive Thirst
Weight Loss	Palpitations	Loss of Urine	Excessive Hair Growth
Weight Gain	Waking up Short of Breath	Urinating Frequently	Psychological
Loss of Appetite	Respiratory	Painful Urination	Anxiety
Eyes	Cough	Skin	Depression
Double Vision	Shortness of Breath at Rest	Rash	Homicidal Ideation
Eye Pain	Shortness of Breath-Exercise	Itching	Suicidal Ideation
Blurred Vision	Sputum	New Skin Lesions	Hematological/Lymphatic
Change in Vision	Wheezing	Neurological	Easy Bleeding
Ear, Nose, Mouth, Throat	Gastrointestinal	Seizures	Easy Bruising
Stuffy Nose	Nausea	Frequent Falls	Lymph Node Enlargement
Runny Nose	Vomiting	Dizziness	Ice Chewing
Ringing in Ear	Diarrhea	Headaches	Allergic/Immunological
Trouble Swallowing	Constipation	Musculoskeletal	Allergic Dermatitis
Sore Throat	Heartburn	Joint Pain	Frequent Illnesses
Ear Pain	Blood in Stools	Joint Swelling	Sinus Allergy Symptoms
Breasts	Black Stools	Muscular Weakness	
Lumps	Abdominal Pain	Back Pain	

Office Use Only	
Reviewed by MD:	Date: