Medications: Please list your current Medications

Medication Name	Dose	Frequency

Drug Allergies

Drug	Type of Reaction

Medical History

Medical Problem/Diagnosis

Surgical History

Surgery	Date

Family History

Family Member	Medical Problem

Social History

Do you smoke tobacco? YES NO If so, how many packs/day? _____

Do you chew tobacco? YES NO

Do you drink alcohol? YES NO If so, how many drinks/day? _____

Do you exercise? YES NO

If so, what activity? _____ How many days/week? _____

System Review

General
Fevers: **Y | N**
Weight Change: **Y | N**
Sweats or Chills: **Y | N**

Head:
Congestion/Runny Nose **Y | N**
Hearing Problems **Y | N**
Sore Throat **Y | N**
Headache **Y | N**

Eyes:
Blurry Vision **Y | N**
Watery Eyes **Y | N**
Redness/Itching **Y | N**

Respiratory:
Shortness of Breath **Y | N**
Chronic Cough **Y | N**
Sputum/Phlegm Production **Y | N**

Cardiovascular:
Chest Pain **Y | N**
Palpitations **Y | N**
Swelling of Legs **Y | N**
Heart Murmur **Y | N**

Gastrointestinal:
Abdominal Pain **Y | N**
Diarrhea **Y | N**
Constipation **Y | N**
Rectal Bleeding **Y | N**

Genitourinary:
Frequency of Urine **Y | N**
Blood in Urine **Y | N**
Genital Discharge **Y | N**

Musculoskeletal:
Migratory Joint Pain **Y | N**
Joint Redness/Swelling **Y | N**
Muscle Cramping **Y | N**

Neurologic:
Seizure **Y | N**
Weakness **Y | N**
Numbness/Tingling **Y | N**

Immunologic:
Seasonal Allergies **Y | N**
Enlarged Lymph Node **Y | N**

Female Only:

Last Menstrual Period

_____

Heavy Bleeding **Y | N**

For ISM Clinical Use:

Vitals: Weight _____ *Height* _____ *BP* _____ *HR* _____ *RR*_____