



**CLINICAL INFORMATIONAL FORM**

PATIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

REFERRED BY: \_\_\_\_\_ FAMILY DR: \_\_\_\_\_

CURRENT MEDICATIONS (include routine and as needed medications): \_\_\_\_\_

\_\_\_\_\_

MEDICATION ALLERGIES: \_\_\_\_\_

PAST SURIGICAL HISTORY: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

FAMILY MEDICAL HISTORY (cancer, diabetes, etc.): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

HAVE YOU HAD ANY X-RAYS (or other diagnostic studies)? IF YES, WHAT AND WHERE? \_\_\_\_\_

\_\_\_\_\_

(FEMALES) ARE YOU PREGNANT? \_\_\_\_\_ YES \_\_\_\_\_ NO

WT \_\_\_\_\_  
HT \_\_\_\_\_

**PAST MEDICAL HISTORY  
REVIEW OF SYMPTOMS**

**PLEASE INDICATE YES OR NO TO THE FOLLOWING:**

- High blood pressure \_\_\_\_\_
- Heart disease, murmur \_\_\_\_\_
- Chest pain \_\_\_\_\_
- Stroke \_\_\_\_\_
- Circulatory problems \_\_\_\_\_
- Liver disease \_\_\_\_\_
- Gallbladder disease \_\_\_\_\_
- Hepatitis \_\_\_\_\_
- Ulcers \_\_\_\_\_
- Hernias \_\_\_\_\_
- Digestive problems \_\_\_\_\_
- Kidney problems \_\_\_\_\_
- Prostate problems \_\_\_\_\_
- Cancer \_\_\_\_\_
- Diabetes \_\_\_\_\_
- Psychiatric disorders \_\_\_\_\_

- Skin disorders \_\_\_\_\_
- Thyroid disorders \_\_\_\_\_
- Infectious disease \_\_\_\_\_
- Seizures/epilepsy \_\_\_\_\_
- Migraines \_\_\_\_\_
- Anemia \_\_\_\_\_
- Arthritis \_\_\_\_\_
- Immune system disorder \_\_\_\_\_
- Tuberculosis \_\_\_\_\_
- Asthma/Emphysema \_\_\_\_\_
- Bronchitis \_\_\_\_\_
- Pneumonia \_\_\_\_\_
- Paralysis \_\_\_\_\_
- Tobacco use \_\_\_\_\_
- Alcohol use \_\_\_\_\_

**Reviewing Physician** \_\_\_\_\_ Date \_\_\_\_\_