Patient Histo					Rocky Mou	ntain 🧐	THE STATE OF THE S		
Patient Name:					-	\			
Birth Date:	Todays Date:			Primary Care Physician:					
Your Pharmacy:			Have any family members been seen here?						
MEDICA		If Yes/Explain:							
Include all known pres				Review o	of System	is (circle or write appl	licable to	you)	
Medication Name	, dietary (nutritional) supplements  Dosage Frequency Ron			CONSTITUTIONAL: fever, weight loss, night sweats					
				EYES: double vision, blurred vision, glaucoma, cataract,  ENT: hearing loss, sinus problems, swallowing problems					
				CV: chest pain, irregular heart beat, palpations, heart problems, high blood pressure					
				RESP:					
				GI: heartburn, reflux, abdominal pain, diarrhea, vomiting, liver disorders, hepatitis  GU: urinary problems, blood in urine, difficulty urinating  MSK: muscle aches, joint pain, swollen joints  SKIN: skin rashes, eczema, itching					
				NEURO: numbness, weakness, headaches, paralysis, seizures, stroke					
Medical Allergies (list reactions):				PSYCHIATRIC: depression, anxiety, manic depressive, schizophrenia					
				ENDOCRINE: hot and cold intolerance, diabetes, thyroid problems					
Environmental Allergies (plants, animals, food,				HEMATOLOGIC/LYMPHATIC: anemic, easy bleeding, lymphoma, leukemia, bleeding disorders					
hayfever, etc):	ALLERGIC/IMMUNOLOGIC: hay fever, allergies, HIV								
Allergy Testing: Reviewed Patient His	tory/Perma	nent Sheet (	clinic only)	□ Pneumo		Date Date Da			
Date Reviewed	Asst MI	_	Reviewed	Asst	MD	Date Reviewed	Asst	MD	
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