HEALTH SUMMARY

1 Wellness Boulevard, Suite 200
Irmo, South Carolina 29063
Phone: (803) 749.1111
Fax: (803) 749-0050

Patient's Name (PLEASE PRINT): ____

Today's Date: _______________ **DOB:** _________________ **SS#:** ______________________

REVIEW OF SYSTEMS: Are you CURRENTLY experiencing any of the following? Please check ALL boxes that apply.

CONSTITUTIONAL
- ☐ Good heath lately
- ☐ Recent weight gain
- ☐ Recent weight loss
- ☐ Fever
- ☐ Fatigue
- ☐ Headaches
- ☐ Other____________________

GENITOURINARY
- ☐ Frequent urination
- ☐ Burning or painful urination
- ☐ Blood in urine
- ☐ Change in force of stream
- ☐ Incontinence or dribbling
- ☐ Kidney stones
- ☐ Sexual difficulty
- ☐ Other____________________

CARDIO/VASCULAR
- ☐ Heart trouble
- ☐ Chest pain
- ☐ Palpitations
- ☐ Varicose veins
- ☐ Other____________________

ALLERGIES
- ☐ Runny/Stuffy nose
- ☐ Watery eyes
- ☐ Itchy nose, eyes and roof of mouth
- ☐ Sneezing
- ☐ Pressure in the nose and cheeks
- ☐ Ear fullness and popping
- ☐ Dark circles under the eyes
- ☐ Hives
- ☐ Other_____________________

SKIN
- ☐ Rash or itching
- ☐ Change in skin color
- ☐ Change in hair or nails
- ☐ Other_____________________

NEUROLOGICAL
- ☐ Frequent or recurrent headaches
- ☐ Light headed or dizziness
- ☐ Convulsions/seizures
- ☐ Numbness or tingling
- ☐ Extremity Weakness
- ☐ Other_________________________

ENDOCRINE
- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Excessive thirst/urination
- ☐ Heat or cold intolerance
- ☐ Other_________________________

EAR, NOSE & THROAT
- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Sore throat
- ☐ Other________________________

SLEEP
- ☐ Snoring
- ☐ Stop breathing/ gasp for air at night
- ☐ Dry mouth/ Sore throat
- ☐ Wake up with headaches
- ☐ Often tired during the day/ while driving
- ☐ Often fall asleep while reading/ watching TV
- ☐ Other________________________

EYES
- ☐ Eye disease or injury
- ☐ Wear glasses/contacts
- ☐ Glaucoma
- ☐ Blurred or double vision
- ☐ Other________________________

HEMATOLOGIC / LYMPHATIC
- ☐ Slow to heal after cuts
- ☐ Easily bruise or bleed
- ☐ Anemia
- ☐ Past blood transfusion
- ☐ Enlarged glands
- ☐ Other____________________

RESPIRATORY
- ☐ Frequent coughing
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Asthma/Wheezing
- ☐ Other____________________

GASTROINTESTINAL
- ☐ Loss of appetite
- ☐ Change in bowel movements
- ☐ Blood in stool
- ☐ Stomach pain
- ☐ Hemorrhoids
- ☐ Nausea/Vomiting
- ☐ Heartburn
- ☐ Other____________________

MENTAL WELLNESS
- ☐ Memory loss
- ☐ Nervousness
- ☐ Depression
- ☐ Other____________________

☐ MUSCULOSKELETAL
- ☐ Joint pain
- ☐ Joint stiffness or swelling
- ☐ Muscle pain/cramps
- ☐ Back pain
- ☐ Other_____________________

HEALTH SUMMARY

DRUG ALLERGIES: Please list ALL medications you are allergic to.

1. ______________________________ 3. ____________________________________ 5. ______________________________

2. ______________________________ 4. ____________________________________ 6. ______________________________

CURRENT MEDICATIONS: Please list ALL meds you are currently taking. Include dosage and how often you take each med.

Current Pharmacy: ________________________ Address: ___________________ Phone: ________________________

Please list any additional medications on a separate sheet of paper

MEDICATION (including over-the-counter)	Strength	HOW OFTEN DO YOU TAKE?

PREVIOUS MEDICAL ILLNESSES: Please check any illnesses you have had in the past.

Please list the year the illness was diagnosed beside any checked box*

- ☐ Anemia / Low Blood
- ☐ Anxiety
- ☐ Asthma
- ☐ Bleeding from Bowels
- ☐ Bleeding Problems, Type: _____
- ☐ Blood Clot in Leg
- ☐ Blood Clot in Lung
- ☐ Blood Transfusion
- ☐ Cancer, Type: _________________
- ☐ Communicable Diseases, Type: ___________________________
- ☐ Congestive Heart Failure
- ☐ Depression
- ☐ Diabetes / High Blood Sugar
- ☐ Emphysema / Chronic Bronchitis
- ☐ Epilepsy / Seizures
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gout
- ☐ Heart Attack
- ☐ Heart Murmur
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Irregular Heart Beat
- ☐ Kidney Disease, Type: _________
- ☐ Kidney Stones
- ☐ Liver Disease, Type: _______
- ☐ Prostate Problems
- ☐ Rheumatic Fever
- ☐ Skin Disease, Type: _______
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers in Bowels / Stomach
- ☐ Varicose Veins or Spider Veins
- ☐ Other: ____________________

____

Health Summary

CURRENT SPECIALISTS:

SPECIALTY	NAME	LOCATION	PHONE #

Females ONLY: Please write N/A on the lines that DO NOT apply to you, or leave blank.

Are you pregnant or planning to be pregnant soon? ☐ Yes ☐ No **Currently breast feeding?** ☐ Yes ☐ No

Number of: Pregnancies? ____ Miscarriages? ____ Deliveries? _____ Abortions? _____

Current form of Birth Control: ______________________

Date of most recent: Pap smear? _______________ Abnormal Pap(s)? _______________

Mammogram? ______________ Abnormal Mammogram(s)? ______________

SURGERY HISTORY:

SURGERY	DATE
Appendectomy	
Joint Scope Surgery	
Biopsy of:	
Open Heart Surgery	
Neck Artery Surgery	
Cataract Surgery ☐ R ☐ L	
Gallbladder	
Broken Bone Repair	
Colonoscopy - Normal/Abnormal	

SURGERY	DATE
Joint Replacement	
Back Disc Surgery	
Abdominal Surgery	
Tonsils Removed	
Prostate Surgery	
Vasectomy	
Hysterectomy	
Other:	

FAMILY HISTORY: Check beside any disease that has affected your parents, brothers, and/or sisters.

******Please write which family member beside any box checked below******

☐ Heart Attack
☐ High Blood Pressure
☐ High Cholesterol
☐ Asthma
☐ Tuberculosis
☐ Liver Disease
☐ Kidney Disease

☐ Osteoporosis
☐ Stroke
☐ Epilepsy / Seizures
☐ Bleeding Problems
☐ Sickle Cell Anemia
☐ Diabetes / High Blood Sugar
☐ Thyroid Problems

☐ Cancer /Type:
☐ Alcohol Abuse
☐ Anxiety or Depression
☐ Glaucoma
☐ Other:

SOCIAL HISTORY:

- **Primary language if not English:** ______________________________
- **Current Employment:** ☐ Full-time ☐ Part-time ☐ Not working ☐ Retired ☐ Student
- **Marital Status:** __________________________
- **Do you have a living will?** ☐ Yes ☐ No
- **Religion:** Describe any ethnic, religious or cultural beliefs you have that may/will influence your treatment. ___________________

____.

CURRENT HEALTH HABITS:

How often do you exercise:	Smoking:	
☐ Never ☐ Rarely ☐ Daily	- Have you ever smoked? ☐ Yes ☐ No - Number of Years: _____	- How many packs currently smoked daily? _____ - Use of smokeless tobacco? ☐ Yes ☐ No - Do you currently smoke? ☐ Yes ☐ No

- **Alcohol consumption:** ☐ Rarely ☐ Socially ☐ Never Quantity? ____________