

**NEW ENGLAND MEDICAL SPECIALISTS**

PATIENT NAME \_\_\_\_\_ DOB \_\_\_\_\_  
PHARMACY \_\_\_\_\_ PHONE # \_\_\_\_\_

CIRCLE IF YOU HAVE ANY OF THE SYMPTOMS LISTED BELOW:

- HEART:** CHEST PAIN SHORTNESS OF BREATH PALIPITATIONS  
HEART SURGERY ANGIOPLASY
- LUNG:** COUGH EMPHYSEMA BRONCHITIS CANCER T.B.
- STOMACH:** ULCER DIARRHEA COLON CANCER BLEEDING CONSTIPATION
- KIDNEY:** PROSTRATE STONES INFECTION
- BRAIN:** STROKE TIA SEIZURE MEMORY LOSS VISION LOSS
- SKIN:** MOLES HAIR LOSS BIRTH MARK
- ENDOCTRINE:** DIABETES THYROID PROBLEM WEIGHT GAIN OR LOSS

**SOCIAL HISTORY**

S/M/W/D  
OCCUPATION \_\_\_\_\_

CIGARETTE SMOKER? YES or NO IF YES, HOW MANY CIGARETTES PER DAY? \_\_\_\_\_  
DO YOU DRINK ALCOHOL? YES OR NO IF YES, HOW MUCH DO YOU DRINK? DAILY? \_\_\_ WEEKLY? \_\_\_

ANY PETS \_\_\_\_\_ SEXUAL HISTORY \_\_\_\_\_

**FAMILY HISTORY**

FATHER \_\_\_\_\_  
MOTHER \_\_\_\_\_  
BROTHER \_\_\_\_\_  
SISTER \_\_\_\_\_

PLEASE LIST THE CURRENT MEDICATIONS YOU ARE ON \_\_\_\_\_  
\_\_\_\_\_

DIET \_\_\_\_\_  
SURGERIES \_\_\_\_\_

CIRCLE: EYEGLASSES ARTIFICIAL LIMBS DENTURES CONTACT LENSES HEARING AID

LAST VACCINATION /DATE:  
TETANUS \_\_\_\_\_ HEPATITIS \_\_\_\_\_ PNEUMONIA \_\_\_\_\_ FLU \_\_\_\_\_