Broadway
MEDICAL CLINIC

Name ____________________
DOB ____________________
Date ____________________

MEDICAL HISTORY		
Drug Allergies		
Present Medications and supplements		
Do you: Smoke? ☐ Drink coffee? ☐ Consume caffeine? ☐	*If yes, how much?* ________ ________ ________	
What operations have you had?	*Procedure* ________ ________ ________ ________	*Approx. date* ________ ________ ________ ________
Have you ever been hospitalized or had any major medical illnesses?		
Do you have any current medical problems?		

FAMILY HISTORY			
Please indicate below if you have a family history of any of the following:			
Condition	Relation to you	Additional Information	
Cancer (please list type)		*Age @ onset*	*Living?*
	________	________	________
	________	________	________
	________	________	________

Dr. Simon 03/2020

FAMILY HISTORY CONT.		
Please indicate below if you have a family history of any of the following:		
Condition	***Relation to you***	***Additional Information***
Heart Disease		
Diabetes		*Type* ______________ *Taking insulin?* ______________
High Cholesterol		
High Blood Pressure		
Ulcers		
Gallstones		
Crohn's Disease		
Ulcerative Colitis		
Other		

CURRENT SYMPTOMS

Please indicate if you have any of the following:

- ☐ Weight gain
- ☐ Weight loss
- ☐ Nighst sweats
- ☐ Fatigue
- ☐ Ear pain
- ☐ Eye pain
- ☐ Nasal drainage
- ☐ Sinus pressure
- ☐ Sore throat
- ☐ Cough
- ☐ Shortness of breath
- ☐ Wheezing
- ☐ Chest pain
- ☐ Ankle/foot/leg swelling
- ☐ Heart palpitations
- ☐ Abdominal pain
- ☐ Constipation
- ☐ Diarrhea
- ☐ Heartburn
- ☐ Loss of appetite
- ☐ Nausea
- ☐ Vomiting
- ☐ Painful urination
- ☐ Increased urinary frequency
- ☐ Urinary incontinence
- ☐ Dizziness
- ☐ Headache
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Back pain
- ☐ Other joint pain
- ☐ Easy bleeding
- ☐ Easy bruising
- ☐ Environmental allergies
- ☐ Other (please specify):

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