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Name: Age: Date:

Please list all your doctors and their specialties (include chiropractors, dentists, podiatrists, and psychologists):

Name of Doctor	Specialty	Phone Number

Please list all your medications (including over the counter pills and vitamins):

Medication or Pill	Dose or Amount	How often taken

List any hospitalizations or operations:

Hospitalization or Operation	Date	Place

List any illnesses or accidents:

Illness or Accident	Date	Place

Please list any other things you feel are important to discuss:

_____

_____

_____

What type of work do you do or have you done:

_____

_____

Living Situation:

Married		Divorced/Separated		Roommate	
Single		Widowed		Partner/Companion	

Please note habits:

Habit	No	Yes	Amount
Tobacco			
Alcohol			
Other Drugs			

Note all that pertain:

Problem	No	Yes	Date Began	Physician Comments
Abdominal Pain				
Balance Difficulties				
Chest Pains				
Constipation				
Decreased Hearing				
Depression				
Diarrhea				
Difficulty Urinating				
Dizziness or Fainting				
Frequent Urination				
Headaches				
High Blood Pressure				
Low Energy				
Muscle Tension				
Nausea or Vomiting				
Numbness				
Shortness of Breath				
Vision Loss				
Weakness				
Weight Loss or Gain				

Please read each area of concern and give your response in the appropriate space related to the degree of the problem for you. Do not answer questions that are not appropriate to you or that you feel uncomfortable answering. To the right of your response is for Dr. Giorgianni's notes regarding each of your responses.
At the bottom, add on other concerns you may have.

Relative to the following areas, how are you doing?

Area of Concern	Degree of Problem			Physician Comments
	None	Some	Serious	
Understanding of your condition				
Knowledge of your medications				
Medication side effects				
Medical care you are receiving				
General Health & Well Being				
Appetite				
Nutrition				
Weight				
Sleep				
Energy Level				
Stress				
Pain				
Bowel Function				
Bladder Function				
Sexual Function				
Walking / getting up from a chair				
Self care (dressing, grooming, etc)				
Home Activities				
Recreation Activities				
Work Activities				
Transportation				
Finances				
Family or Friend Support				