THOMAS E. BOWSER, M.D., PLLC DATE_____

NAME_____**AGE**_____**DATE OF BIRTH**_____**SEX: M F**

REFERRING M.D._____PRIMARY M.D._____

HEIGHT_____WEIGHT_____ RIGHT OR LEFT HANDEI

Why did your physician want you to see Dr. Bowser today?_____

_____

MEDICATIONS: (Please list medications and dosages)

ALLERGIES: (Please list allergies to medications)_____

CONDITIONS: (Please list conditions you have or had in the past)

- □ AIDS
- □ Alcoholism
- □ Anemia
- □ Anorexia
- □ Appendicitis
- □ Arthritis
- □ Asthma
- □ Bipolar Disorder
- □ Bleeding Disorders
- □ Breast Lump
- □ Bronchitis
- □ Bulimia
- □ Cancer
- □ Carpal Tunnel Syndrome
- □ Cataracts
- □ Chemical Dependency
- □ Chicken Pox
- □ Depression
- □ Diabetes
- □ Emphysema
- □ Epilepsy
- □ Fibromyalgia
- □ Glaucoma
- □ Goiter
- □ Gonorrhea
- □ Gout
- □ Heart Disease
- □ Hepatitis
- □ Hernia
- □ Herniated Disk
- □ Herpes
- □ High Blood Pressure
- □ High Cholesterol
- □ HIV Positive
- □ Kidney Disease
- □ Liver Disease
- □ Low Back Pain
- □ Measles
- □ Migraine Headaches
- □ Miscarriage
- □ Mononucleosis
- □ Multiple Sclerosis
- □ Mumps
- □ Neck Pain
- □ Neuropathy
- □ Osteoporosis
- □ Pace Maker
- □ Pneumonia
- □ Polio
- □ Prostate Problems
- □ Psychiatric Care
- □ Rheumatic Fever
- □ Ruptured Disk
- □ Scarlet Fever
- □ Stroke
- □ Suicide Attempt
- □ Thyroid Problems
- □ Tonsillitis
- □ Tuberculosis
- □ Typhoid Fever
- □ Ulcers
- □ Vaginal Infections
- □ Venereal Disease

Major Illness, Surgeries, or Hospitalizations: (Please Provide approximate year of illness or surgery)

_____

_____

_____

_____

_____

_____

_____

OCCUPATIONAL CONCERNS:

Have you filed a Work Injury report with your employer? YES NO

Date of Injury_____

Is there a lawsuit planned related to the current medical problem? YES NO

Your Occupation:_____

Health Habits:				
	Regular Exercise	YES	NO	
	Tobacco	YES	NO	packs/day? _____
	Alcohol	YES	NO	how much? _____
	Recreational Drugs	YES	NO	

FAMILY HISTORY

Father: Age_____ Condition of Health_____ Deceased at age _____ Cause of death _____

Mother: Age_____ Condition of Health_____ Deceased at age _____ Cause of death _____

Siblings: Ages_____Conditions of health_____

Are you married?_____Years?_____Spouse's age_____Health of Spouse_____

If spouse deceased, give age and cause of death_____

Number of children: Boys_____Ages_____Girls_____Ages_____All healthy?_____

Have any members of your family ever had the following?

- □ Allergy
- □ Alzheimer Disease
- □ ALS
- □ Arthritis
- □ Cancer
- □ Diabetes
- □ Epilepsy
- □ Headaches / Migraines
- □ Heart Disease
- □ High Blood Pressure
- □ Multiple Sclerosis
- □ Nervous Trouble
- □ Parkinson's Disease ./ Tremor
- □ Stomach Trouble
- □ Stroke
- □ Other Disease_____

CONSTITUTIONAL SYMPTOMS: (mark any symptoms that you may have)

GENERAL
- □ Weight change
- □ Loss of appetite
- □ Fever
- □ Tiredness
- □ Fatigue
- □ Night sweats

DERMATOLOGY
- □ Rash
- □ Lumps
- □ Redness
- □ Itching
- □ Tattoos
- □ Dry Skin

ENDOCRINE
- □ Excessive sweating
- □ Excessive thirst
- □ Heat intolerance
- □ Cold intolerance
- □ Diabetes
- □ Menstrual irregulatities
- □ Swelling

NEUROLOGY
- □ Headache
- □ Numbness or tingling
  Where?_____
- □ Seizures
- □ Dizziness
- □ Balance problems
- □ Memory problems
- □ Tremors
- □ Pain
- □ Falls
- □ Slurred speech
- □ Twitching muscles
  Where?_____

OPHTHALMOLOGY
- □ Diminished vision
- □ Blurring of vision
- □ Cataracts
- □ Watery eyes
- □ Double vision

HEMATOLOGY
- □ Blood transfusion
- □ Easy bruising

ENT / RESPIRATORY
- □ Cold and cough
- □ Hearing loss
- □ Change in voice
- □ Sore throat
- □ Ringing in ears
- □ Hoarseness of voice
- □ Dizziness
- □ Shortness of breath
- □ Asthma
- □ Difficulty swallowing
- □ Sinus problems
- □ Room spinning sensation
- □ Emphysema
- □ Cough
- □ Nosebleeds
- □ Sleep Apnea

CARDIOLOGY
- □ Chest pain
- □ Palpitations / irregular heartbeat
- □ Leg swelling
- □ Shortness of breath
- □ Passing out
- □ History of heart attack

GASTROENTEROLOGY
- □ Nausea
- □ Heartburn
- □ Vomiting
- □ Difficulty swallowing / Choking
- □ Abdominal pain
- □ Diarrhea
- □ Constipation
- □ Blood in Stool

MUSCULOSKELETAL
- □ Joint stiffness
- □ Leg cramps
- □ Joint pain
- □ Joint swelling
- □ Neck pain
- □ Back pain
- □ Shooting leg pain
- □ Shooting arm pain
- □ Muscle aches
- □ Spasms

PSYCHOLOGY
- □ Depression
- □ Tension / Stress
- □ Irritability
- □ Anxiety
- □ Attention deficit
- □ Cry often
- □ Personality changes
- □ Hyperactivity
- □ Attention deficit
- □ Agitated / Combative
- □ Hallucinations
- □ Sleep disturbances
- □ Sleep walking
- □ Bedwetting after age 12

GENITO-URINARY MALE
- □ Difficulty urinating
- □ Increased urinary frequency
- □ Erectile dysfunction
- □ Prostate problems

GENITO-URINARY FEMALE
- □ Increased urinary frequency
- □ Urinary incontinence
- □ Urinary urgency
- □ Stress incontinence
- □ Lack of sexual interest

Please list Physicians whom you would like for us to send a report to:

◊_____ ◊_____

◊_____ ◊_____

Patient Signature_____