LEHIGH VALLEY WELLNESS CENTER
101 Coventry Drive
Phillipsburg, New Jersey 08865

Patient:_____ Date of Birth:_____

Health History:_____
_____

Any Previous Hospitalizations or Surgery:
_____
_____
_____

Medications Name and Dosage:

1._____ 2._____
3._____ 4._____
5._____ 6._____
7._____ 8._____

Allergies:

_____

Family History:_____

Do You Use (how often and how much):
Alcohol:_____
Tobacco:_____
Drugs:_____

REVIEW OF SYSTEMS

___ Recent Weight Changes
___ Weakness
___ Fever
___ Night Sweats
___ Cough
___ Sputum Production
___ Blood in Sputum
___ Asthma, Bronchitis
___ Emphysema
___ TB
___ Rashes
___ Easy Bruising
___ Color Change (skin)
___ Excessive Dryness (skin)
___ Excessive Perspiration

___ Changes in Nail/Hair
___ Headaches
___ Vision Problems
___ Glaucoma or Cataracts
___ Dry Eyes
___ Earaches
___ Sinus Problems
___ Thyroid Problems
___ Chest Pain
___ Shortness of Breath
___ Leg Swelling
___ Heartburn
___ Nausea or Vomiting
___ Diarrhea
___ Constipation

___ Urination Problems
___ Arthritis
___ Back pain
___ Neck pain
___ Other Pain _____
___ Numbness in Hands/Feet
___ Seizures
___ Tremors
___ Dizziness
___ Depression
___ Anxiety
___ Itching
___ Changes in Appetite
___ Other, please specify
_____
_____