EASTERN RADIOLOGICAL ASSOCIATES

Patient Name:	DOB:
Current Medical History: What is your reason for coming to our office today?	
Please give the history of your current problem (when it started, symptoms; treatment?	
Drug Allergies (include medication name and reaction type):	

Current medications (include prescription, over-the-counter, and herbals)

Name of Medicine	Dose	How often taken	Reason for taking

Patient, please do not write in this space

BP:	HR:	
RR:	Pain:	
HT:	WT:	

Past Medical History (Please check ALL previous illness or conditions below)

Heart and Blood Vessels	**Brain and Nerves**	**Lungs**	**Stomach/Intestines**
☐None	☐None	☐None	☐None
☐Heart failure	☐Headaches	☐Asthma	☐GERD
☐High blood pressure	☐Alzheimer's/Dementia	☐COPD	☐Crohn's Disease
☐Heart attack	☐Seizures	☐Tuberculosis	☐Irritable Bowel
☐Stroke	☐Stroke	☐Sleep apnea	☐Pancreatitis
☐High Cholesterol	☐Multiple Sclerosis		
Kidney/Bladder	**Blood Disorders**	**Immune**	Joints/Skeleton
☐None	☐None	☐None	☐None
☐Kidney failure	☐Anemia	☐HIV/AIDS	☐Osteoporosis
	☐Bleeding disorders	☐Rheumatoid Arthritis	☐Arthritis
	☐Clots		
Liver	**Endocrine**	**Psychological**	**Cancer**
☐None	☐None	☐None	☐None
☐Hepatitis	☐Thyroid disease	☐Depression	☐Type
☐Cirrhosis	☐Diabetes	☐Anxiety	_____
		☐Addiction	

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Past Surgeries:	
Past Hospitalizations:	
Review of Systems: The following should be answered for medical problems you are having now.	
To be completed by Patient	*To be completed by provider*
General ☐None ☐Fever/Chills ☐Change in Weight ☐Pain - location ☐Other: _____	
Neurological ☐None ☐Dizziness ☐Numbness/tingling ☐Vision Problems ☐Headache ☐Hearing problems ☐Seizures ☐Other: _____	
Head & Neck ☐None ☐Problems swallowing ☐Other: _____	
Cardiovascular ☐None ☐Edema ☐Chest pain ☐Blood pressure problems ☐Other: _____	
Respiratory ☐None ☐Wheezing ☐Cough ☐Shortness of Breath ☐Other: _____	

Gastrointestinal ☐None ☐Nausea/Vomiting ☐Abdominal Pain ☐Constipation ☐Diarrhea ☐Blood in Stool ☐Other: _____			
Genitourinary ☐None ☐Problems with Urination ☐Others: _____			
Musculoskeletal ☐None ☐Joint swelling/pain ☐Neck pain ☐Back pain ☐Other:			
Family History (Mother, Father, and Siblings):			
Social History			
Do you:	☐drink alcohol Amt/week: _____	☐drink caffeine Cups/day:_____	☐Use Tobacco products Type: _____ Amt/day: _____
Occupation:			