Keith Jackson M.D.

Please take the time to answer the following questions.
Fill in any spaces where information is requested.
Place a check on the line in front of the symptom or illness that applies to you

Patient Name (print): Date:

What Medications do you take daily including?

- **ASA } Ibuprofen Supplements**
-
-

Please list any prior SURGERIES:

-
-
-

Do you have any Drug ALLERGIES?

-
-

Smoke/ Chew tobacco □yes □no
Alcohol { } Other:

Constitutional:
_____ Fever
_____ Chills
_____ Weight Loss

Respiratory:
____ Wheezing
____ Cough
____ Shortness of breath

Cardiovascular:
____ Heart Palpitation
____ Fast/Slow Heart Rate
____ Heart Disease
____ Chest Pain
____ High Blood pressure

Gastrointestinal:
____ Abdominal pain
____ Vomiting
____ Constipation
____ Diarrhea
____ Heart burn

Musculoskeletal:
____ Joint or back pain

Integumentary:
____ Dry Skin
____ Itchy Skin
____ Change in mole size

Neurologic:
____ Headaches
____ Seizures
____ Dizziness
____ Fainting

Psychiatric:
____ Anxiety
____ Depression
____Bipolar disorder
____ Schizophrenia

Endocrine:
____ Thyroid disorder
____ Eye swelling
____ Diabetes

Hematology:
____ Easy bruising
____Easy bleeding
____ Swollen Glands

Genitourinary:
____ frequent urination
____ Painful urination
____ Hesitancy
____ Kidney Problem

Other:
____ HIV/AIDS
____ Hepatitis
____ Cancer: _____

****Please indicate if there has been a family history of: (please circle) ****

_____Sinusitis: Mom/ Dad/ other: _____ ____Hearing Loss: Mom/ Dad/ other: _____
_____Head and Neck Tumors: Mom/ Dad/ other: _____
_____Allergic Rhinitis: Mom/Dad/other: _____ Fall Screening 65+:Falls in the past year □yes □no #_____

I acknowledge this is true and correct: (sign)