



Hybrid MD

FOR THE FOLLOWING CONDITIONS, PLEASE CHECK IF YOU CURRENTLY HAVE:

General Health:

Fever Chills Recent weight loss Other

Neurological:

Dizziness Headaches Numbness Weakness

Eyes:

Change in vision Pain Redness Discharge

Ears, Nose & Throat:

Earache Ear discharge Sinus congestion Sore throat

Neck Region:

Mass Swollen Glands Stiffness Other

Thyroid:

Tenderness Neck Mass Other: _____

Cardiovascular (Heart):

Chest pain Palpitations Abnormally rapid heartbeat (flutter)

Respiratory (Lungs):

Restrictions Wheezes Cough Shortness of breath

Gastrointestinal:

Pain Nausea Vomiting Diarrhea Constipation

Genitourinary:

Blood with urination Burning with urination Urgency Frequency

Skin:

Rash Ulcers Lesions Abrasions

Musculoskeletal:

Muscle pain Joint pain Edema Other _____

_____/_____/_____
Patient's Last Name Patient's First Name Date Patient's Signature (Representative if minor)

Primary Doctor (PCP): _____

PCP Phone #: _____

Preferred Pharmacy Name & Address: _____

(please let us know _____
if there's a change) _____

Pharmacy Phone #: _____