|  |  |  |
| --- | --- | --- |
| Date: | Name: | DOB: |

**Reason for your visit today\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SOCIAL HISTORY**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
|  | Yes | No | How Much Per Day/Week | Date Quit |
| Tobacco |  |  |  |  |
| Alcohol |  |  |  |  |
| Caffeine |  |  |  |  |
| Chewing Tobacco |  |  |  |  |

**REVIEW OF SYSTEMS**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Please check yes or no to the following based on your recent symptoms | | | | | | | | |
| CONSTITUTIONAL | Y | N | HEMATOLOGY | Y | N | MUSCULOSKELETAL | Y | N |
| Fever |  |  | Gums Bleed Easy |  |  | Joint Pain/Swelling |  |  |
| Weight Loss |  |  | Bruising |  |  | Stiffness |  |  |
| Fatigue |  |  | Swollen Glands |  |  | Muscle Pain |  |  |
| DERMATOLOGY |  |  | Varicose Veins |  |  | Back Pain |  |  |
| Itching |  |  | RESPIRATORY |  |  | Rash/Sore |  |  |
| Bruising |  |  | Cough Easy |  |  | Lesions |  |  |
| Rash |  |  | Coughing Blood |  |  | Itching/Burning |  |  |
| Moles |  |  | Wheezing |  |  | PSYCHOLOGY |  |  |
| Lumps |  |  | Chills |  |  | Anxiety/Depression |  |  |
| Skin Cancer |  |  | CARDIOLOGY |  |  | Mood Swings |  |  |
| ENDOCRINOLOGY |  |  | Murmur |  |  | Difficult Sleeping |  |  |
| Loss of Hair |  |  | Chest Pain |  |  | GENITOURNINARY(male) |  |  |
| Polydipsia |  |  | Palpitations |  |  | Burning/Frequency |  |  |
| Hypothyroidism |  |  | Dizziness |  |  | Nighttime |  |  |
| OPHTHALOMOLOGY |  |  | Fainting Spells |  |  | Blood in Urine |  |  |
| Glasses/Contacts |  |  | Shortness of Breath |  |  | Erectile Dysfunction |  |  |
| Eye Pain |  |  | GASTROENTEROLOGY |  |  | Abnormal Discharge |  |  |
| Double Vision |  |  | Heartburn/Reflux |  |  | Bladder Leakage |  |  |
| Cataracts |  |  | Nausea/Vomiting |  |  | GENITOURINARY(female) |  |  |
| NEUROLOGY |  |  | Constipation |  |  | Bladder Leakage |  |  |
| Loss of Strength |  |  | Change in BM’s |  |  | Heavy Periods |  |  |
| Numbness |  |  | Diarrhea |  |  | Pelvis Pain |  |  |
| Headache |  |  | Jaundice |  |  | Hot Flashes |  |  |
| Tremors |  |  | Abdominal Pain |  |  | Date of Last Mammogram |  |  |
| Memory Loss |  |  | Black or Bloody BM |  |  | Was it Normal |  |  |
| Seizures |  |  |  |  |  |  |  |  |

**VITALS**

|  |  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- | --- |
| **BP** |  | **HR** |  | **WT** |  | **HT** |  | **TEMP** |  |



|  |  |  |
| --- | --- | --- |
| Date: | Name: | DOB: |

**CURRENT MEDICATIONS**

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| --- | --- |
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**MEDICAL HISTORY**

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| --- | --- | --- | --- | --- | --- |
| **Please mark the column titled “You” if you have been diagnosed with any of the following illness.**  **If you have a family member who suffers from one of the following illnesses, write their relationship to you under**  **“Family Member**” | | | | | |
| Illness | YOU | Family Member | Illness | YOU | Family Member |
| EXAMPLE | X |  | Kidney Disease |  |  |
| EXAMPLE |  | MOTHER | Liver Disease |  |  |
| Alcoholism |  |  | Lung Disease |  |  |
| Anemia |  |  | Mental Illness |  |  |
| Asthma |  |  | Osteoarthritis |  |  |
| Cancer/Tumor |  |  | Osteoporosis |  |  |
| Diabetes |  |  | Phlebitis |  |  |
| Drug Abuse |  |  | Rheumatic Arthritis |  |  |
| Depression |  |  | Stroke |  |  |
| Epilepsy/Seizures |  |  | Suicide Attempt |  |  |
| Glaucoma |  |  | Thyroid Disease |  |  |
| Heart Disease |  |  | Tuberculosis |  |  |
| Hepatitis |  |  | Ulcer in GI tract |  |  |
| High Blood Pressure |  |  | Venereal Disease |  |  |
| High Cholesterol |  |  | Other: |  |  |
| HIV Immune DX |  |  |  |  |  |

**ALLERGIES** **None Known**

|  |  |
| --- | --- |
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**SURGICAL HISTORY**

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| --- | --- | --- | --- |
| Date | Surgery | Date | Surgery |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |