

Patient name \_\_\_\_\_ Age \_\_\_\_\_ Pt # \_\_\_\_\_ Date \_\_\_\_\_

Allergies:
Current medications:

Reason for today's visit: (chief complaint)

\_\_\_\_\_

\_\_\_\_\_

Current or past problems with: (Review of systems)

	Yes	No	(if yes, explain)
General Health	<input type="checkbox"/>	<input type="checkbox"/>	_____
Eyes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Ears/Nose/Throat/Mouth	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart	<input type="checkbox"/>	<input type="checkbox"/>	_____
Lungs	<input type="checkbox"/>	<input type="checkbox"/>	_____
Stomach/bowel	<input type="checkbox"/>	<input type="checkbox"/>	_____
Kidneys	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis/muscles/joints	<input type="checkbox"/>	<input type="checkbox"/>	_____
Skin	<input type="checkbox"/>	<input type="checkbox"/>	_____
Headaches/seizures	<input type="checkbox"/>	<input type="checkbox"/>	_____
Psychological disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Thyroid/diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____
Blood/bleeding disorder	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergic/immunologic	<input type="checkbox"/>	<input type="checkbox"/>	_____

Females: are you pregnant? \_\_\_yes \_\_\_no planning to become pregnant? \_\_\_yes \_\_\_no

Family History: (Past family and social history)

Mother: living/deceased \_\_\_age\_\_\_ Father: living/deceased \_\_\_age\_\_\_ Do you have children? \_\_\_age(s)\_\_\_

Check following medical conditions that have occurred in your family:

<u>Disease</u>	<u>Mother</u>	<u>Father</u>	<u>Blood Relative</u>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Hayfever	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Heart disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Lung disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Malignant Melanoma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Skin cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Social History:

Do you live alone? \_\_\_no \_\_\_yes Do you smoke? \_\_\_no \_\_\_yes-frequency\_\_\_\_\_

Do you drink alcohol? \_\_\_no \_\_\_yes-frequency\_\_\_\_\_ Do you use recreational drugs? \_\_\_no \_\_\_yes-frequency\_\_\_\_\_

Occupation\_\_\_\_\_ Hobbies/leisure activities\_\_\_\_\_

Reviewed\_\_\_\_\_ Date\_\_\_\_\_ Update\_\_\_\_\_

(MD signature)