Name _____ Today's Date _____

Social History (Please answer the following questions)

Do you use tobacco? _____ How much a day_____

Are you interested in stopping? _____

Have you stopped using tobacco? _____ If so, when? _____

Alcohol: Type _____ Amount _____

Caffeine: _____ cups daily

Education _____

Occupation _____

Exercise routine _____

Single Married Divorced Separated Widowed

Allergies: _____

_____

_____

MEDICATIONS: Please list all of the medications you are taking. Include over-the-counter drugs and vitamins.

_____ Dose: _____

_____ Dose: _____

_____ Dose: _____

_____ Dose: _____

_____ Dose: _____

_____ Dose: _____

_____ Dose: _____

_____ Dose: _____

_____ Dose: _____

_____ Dose: _____

Name_____ Date of Birth_____ Today's Date_____

How did you find out about our office (friend, physician referral, etc.)? _____

List the name of your Primary Care Physician _____

Chief complaint _____

History of present illness (these lines are for physician use only) _____

_____

_____

_____

_____

Past Medical History (Please check any that apply to yourself)

Allergies	Emphysema/COPD	Liver disease or hepatitis
Anxiety	Enlarged prostate	Psoriasis/Eczema
Arrhythmia	Heart attack (MI)	Reflux
Arthritis	Heart murmur	Seizure/epilepsy
Asthma	Heart failure	Stomach ulcers
Bronchitis	High blood pressure	Stroke
Depression	High cholesterol	Thyroid disorder
Diabetes	Kidney stones	Urinary infections
Glaucoma	Cancer _____	
Headache	Other	

Surgeries: (Please check any surgeries you have had)

Angioplasty	Cataracts	Hysterectomy
Appendectomy	C-section	Prostate surgery
Back	Gallbladder	Tonsillectomy
Bypass	Hernia	Other _____

Review of Systems (Please circle any of the following symptoms you have.)

GENERAL	Appetite change	Weight change	Fever	Chills
	Fatigue	Night sweats		
HEENT	Headache	Vision changes	Dizziness	Hearing problems
	Runny nose	Snoring	Nose bleeds	Congestion
	Sore throat	Eye pain	Difficulty swallowing	Ear pain Allergies
NECK	Swollen glands	Pain	Stiffness	Thyroid enlargement
CV	Chest pain	Swollen ankles	Palpitations	Passing out
PULM	Cough	Wheezing	Shortness of breath	
GI	Nausea	Vomiting	Diarrhea	Abdominal pain
	Constipation	Bloody stool	Tarry stools	Changes in bowels
	Indigestion	Heartburn	Jaundice	Hemorrhoids
GU	Painful urination	Vaginal discharge	Sexual dysfunction	Loss of control of urine flow
	Frequent urination	Breast problems	Problems with periods	
NEURO	Seizures	Tingling	Numbness	Tremor
MS	Joint pains	Muscle weakness	Shoulder pain	
PSYCH	Anxious/Nervous	Depressed	Stressed	Sleep trouble
ENDO	Increased thirst	Breast discharge	Skin change	Weather intolerance
SKIN	Rash	Changing moles	Blotching	Hives
OTHER	_____			