

Patient's Name: _____

PAST MEDICAL HISTORY: (PLEASE CIRCLE YES OR NO)

YES NO HOSPITALIZATION

YES NO INJURIES

YES NO CANCER

YES NO SURGERY (type) _____

YES NO DIABETES, HIGH BLOOD PRESSURE ASTHMA

YES NO HEART DISEASE HIGH CHOLESTEROL

If yes, describe:

Drug Allergies: _____

Medications:

Drug Name

Dose

Drug Name

Dose

Drug Name	Dose	Drug Name	Dose
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

FAMILY HISTORY: Has Mom, Dad, Brother or Sister ever had (circle family member):

Heart Disease: M D B S age at diagnosis: _____

Diabetes: M D B S age at diagnosis: _____

Cancer: M D B S age at diagnosis: _____

SOCIAL HISTORY:

Marital Status: M S D W

Occupation: _____

Tobacco: _____ Packs per day _____ years

Alcohol: _____ Drinks per week

Patients Name: _____

Review of Systems: (Circle all that apply)

GENERAL: Fever, Chills, Fatigue

HEAD AND NECK: Sore throat, Ear ache, Runny nose, Nasal drip

CARDIOVASCULAR: High BP, High Cholesterol, Chest Pain, Heart Murmur, Palpitations

RESPIRATORY: Cough, Wheeze, Asthma, Bronchitis, +PPD

GASTROINTESTINAL: Heartburn, GERD, Indigestion, Gallstones, Rectal bleeding

MUSCULOSKELETAL: Joint pain, Muscle pain, Arthritis

SKIN: Rash, Lesion, Itch

NEUROLOGIC: Headache, Numbness, Tingling, Seizures, Fainting, Passed-out

PSYCHIATRIC: Depression, Anxiety, Bipolar,

ENDOCRINE: Weight Loss, Weight Gain, Thyroid trouble, Sweating

OTHER SYMPTOMS: _____
