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)
Asthma	( )	( )	____________________
Diabetes	( )	( )	____________________
General Health	( )	( )	____________________
Eyes	( )	( )	____________________
Ears/Nose/Throat/Mouth	( )	( )	____________________
Heart	( )	( )	____________________
Lungs	( )	( )	____________________
Stomach/Bowel	( )	( )	____________________
Kidneys	( )	( )	____________________
Arthritis/muscles/joints	( )	( )	____________________
Skin	( )	( )	____________________
Headaches/Seizures	( )	( )	____________________
Psychological disorder	( )	( )	____________________
Thyroid	( )	( )	____________________
Blood/Bleeding disorder	( )	( )	____________________
Allergic/Immunologic	( )	( )	____________________
Hepatitis	( )	( )	____________________

Females: are you pregnant? ______Yes ____ No planning to become pregnant? _______Yes ____No

Family History:
Mother: Living/Deceased ________age_____Father: Living/Deceased_________age_____
No. of children__________age(s)____

Check the following medical conditions that have occurred in your family (if applicable.)

	Mother	Father	Blood relative	
Disease	( )	( )	( )	____________
Allergies	( )	( )	( )	____________
Arthritis	( )	( )	( )	____________
Asthma	( )	( )	( )	____________
Cancer	( )	( )	( )	____________
Diabetes	( )	( )	( )	____________
Eczema	( )	( )	( )	____________
Hayfever	( )	( )	( )	____________
Heart Disease	( )	( )	( )	____________
High Blood Pressure	( )	( )	( )	____________
Lung Disease	( )	( )	( )	____________
Malignant Melanoma	( )	( )	( )	____________
Psoriasis	( )	( )	( )	____________
Skin cancer	( )	( )	( )	____________
Tuberculosis	( )	( )	( )	____________

Social History:

Do you live alone? ______Yes ____No

Do you use recreational drugs? ____Yes ___No_____________ Frequency

Do you drink alcohol?___Yes ____No ____________Frequency

Do you smoke?___Yes __No ____________Frequency

Occupation___________________________

Hobbies/Leisure activities_____________________________________

Reviewed_________________________________ Date________________ Update____________________

(MD Signature)